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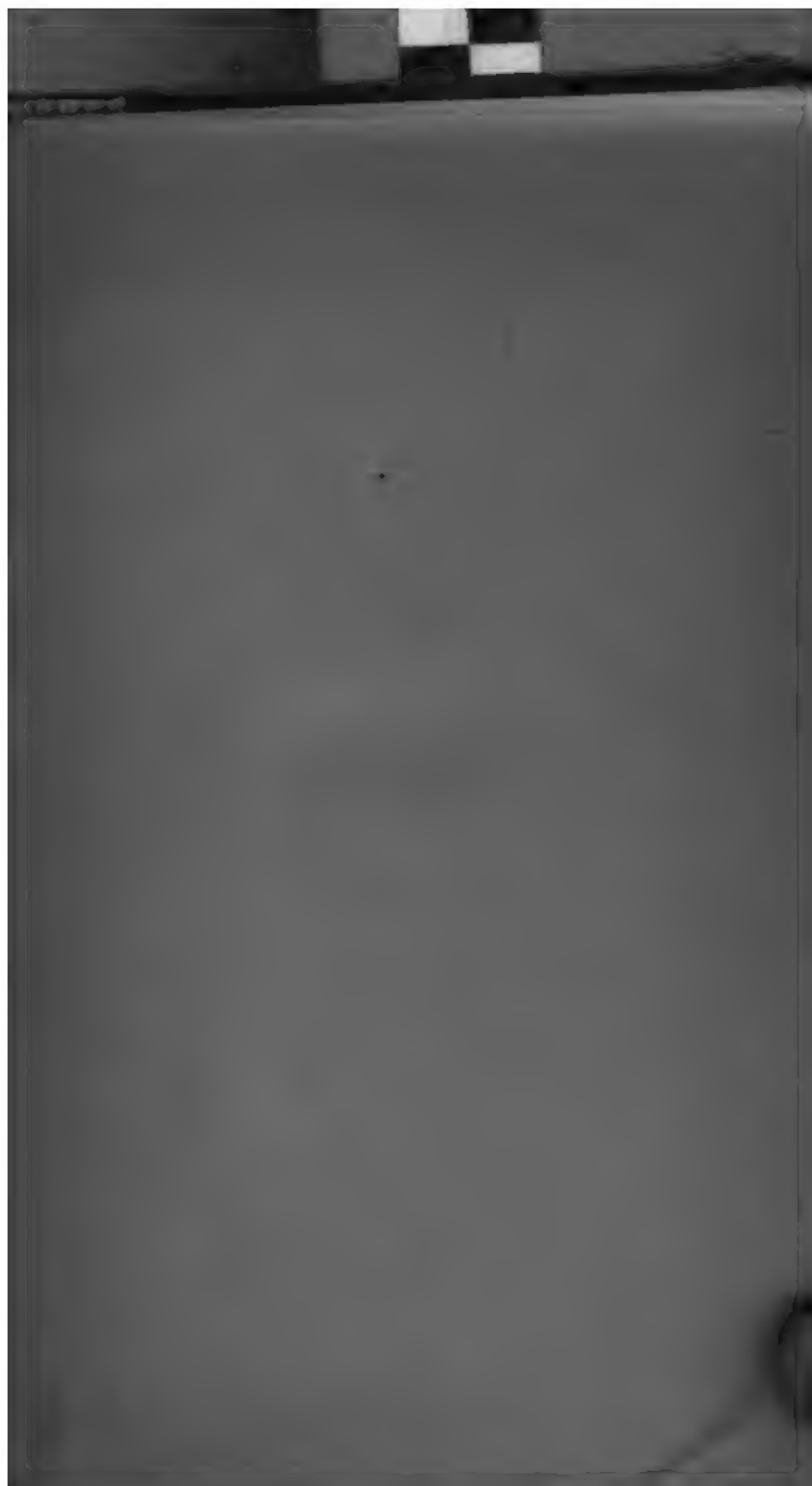
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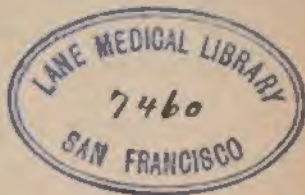
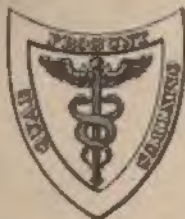
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PREFACE TO THIRD EDITION.

IN the preparation of this third edition, it has been found necessary almost wholly to rewrite the book in order to note the important changes that have taken place during the last ten years in the planning and execution of many of the operations that have been preserved, to substitute others, and to make the numerous additions.

Of the operations formerly in vogue, a number have been left out because they had their origin and found their usefulness only in conditions and dangers of the process of repair that are now rarely met with, and others because superior substitutes have been introduced. The most important additions and modifications have been made in the surgery of the cranium and of the abdomen.

To Dr. Rogers has fallen all the labor of collecting and making the descriptions, seeking and verifying references, obtaining the cuts and drawings, and of composition. He had my advice and assistance in the selection of subjects, and I revised the manuscript before publication and read all the proof.

LEWIS A. STIMSON.

NEW YORK,
34 EAST THIRTY-THIRD STREET,
October, 1895.



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OPERATIVE SURGERY.

PART I.

THE ACCESSORIES OF AN OPERATION.

ANÆSTHESIA.

Local anæsthesia may be obtained (1) by the action of cold, or (2) by the application of an agent which exerts locally a benumbing effect upon the nerves.

1. The low temperature which produces local anæsthesia may be obtained by the application to the parts of a freezing mixture (ice and salt), or by the vaporization of ether or ethyl chloride. The former is applicable to larger surfaces than the latter. A mixture of cracked ice and salt is put in a muslin bag and laid upon the part, and a folded compress or towel laid over it to intensify its action. After it has been in place two or three minutes it should be removed, the sensibility of the skin tested, and the bag reapplied if the desired effect has not been produced. When chilled to insensibility the skin is white and puffy.

When ether is used for local anæsthesia it should be directed upon the parts in a fine spray, or its rapid vaporization should be aided by fanning or blowing upon the surface. It is inefficient when the skin is very vascular.

2. Carbolic acid is an efficient and convenient means of producing local anæsthesia. A cloth thoroughly wet with a 3 per cent. solution of the acid should be kept upon the skin for fifteen minutes, and then the undiluted acid applied with a brush along the line of the proposed incision. This is applicable to the opening of abscesses, felonæ, etc., and to many minor operations.

Hydrochlorate of Cocaine. The injection under the skin or into a nerve of a few drops of a 2 or 4 per cent. solution of the hydrochlorate of cocaine produces a temporary local anæsthesia, sufficient to permit the painless performance of an operation involving only the skin or the layers immediately underlying it. A deeper injection into a nerve produces anæsthesia of the region supplied by it. As this agent acts upon the nerve-fibres, the injection should be made on the proximal side of the region to be operated upon, and should be directed toward and into that region.

General Anæsthesia. The agents in common use for producing general anæsthesia are (1) ether, (2) chloroform, and (3) nitrous oxide.

The great merit of ether is in safety. Chloroform is more rapid in its action at first, as usually given, at least less liable to cause vomiting, less disagreeable in its after-effects, but it is certainly more dangerous. On account of its inflammability, ether should be used with caution at night, and as its vapor is heavier than air, the lights should be held above the bed. Nitrous oxide is suitable only for very short operations. Its use to obtain anæsthesia for any length of time is as dangerous as that of chloroform, perhaps more so.

Ether endangers life through suffocation, which may be the result of paralysis of the respiratory muscles, or of obstruction of the air-passages by the tongue, or by a foreign body, such as vomited matter. Chloroform kills by exerting a special influence upon the ganglionic nerve-centres presiding over respiration and circulation. Arrest of the breathing and lividity of the surface give timely notice of danger from ether. Chloroform may kill without a moment's warning.

If during anæsthetization by ether the respiratory muscles cease to act, artificial respiration should be kept up, and stimulants administered; but the patient should be kept quiet, should not be whipped or excited to muscular action. The danger comes from the weakness of his muscles, and they must not be called upon for any extra exertion. If, as is much more common, the diaphragm acts, but the air-passages are obstructed, and the face becomes livid, the

obstruction must be removed, and the breathing will then take care of itself. If the obstruction is due to the presence of a foreign body in the glottis or trachea (false teeth, vomited matter), the shoulders and head must be lowered, and the hips raised. It may become necessary to resort to tracheotomy. If the obstruction is due to the falling back of the tongue in consequence of the relaxation of the muscles of the pharynx and floor of the mouth, a stout piece of wood should be put between the patient's teeth and his tongue drawn forward. The most prompt and efficient way of doing this is for the operator to hook the terminal joint of his forefinger behind the root of the tongue and draw it forward, or the fingers should be pressed upward and inward from below the angles of the jaw.

When operating upon the mouth and nasal passages, hemorrhage may interfere seriously with respiration and anesthetization. By placing the patient on his back, and allowing his head to hang down over the end of the operating table, the blood will be made to flow away through the nostrils, and the larynx will remain clear.

During the inhalation of chloroform, death may occur either suddenly by syncope, or more slowly with signs of cerebral congestion and arrest of hematosis. In the first case the heart stops, the patient becomes pale, the respiration superficial; the other usually happens after consciousness has returned, the face suddenly becomes livid, the patient loses consciousness again, and dies within half an hour. In the first variety, death can generally be averted by lowering the head, slapping the breast and face with wet towels, and applying the galvanic or faradic current. When the galvanic current is used, the negative pole may be placed in the mouth, and the positive pole at the anus. The faradic current should be applied only over the chest; its application to the phrenic or pneumogastric nerves in the neck is dangerous. In the second variety death is apparently inevitable.

By the inhalation of nitrite of amyl impending death may sometimes be averted.

Administration of the Anæsthetic. Chloroform should be given upon a compress folded twice longitudinally and once

transversely, so as to be about six inches square. The upper fold is then thrown back, a drachm of chloroform poured upon the lower one, and the upper one replaced to prevent evaporation from that side. The compress is then held before the mouth and nostrils of the patient, and whenever necessary the upper fold is thrown back, and additional chloroform poured upon the lower one. No special instrument is needed to prevent the administration of too much at a time. It has been demonstrated that the amount of the vapor of chloroform in the air never exceeds $4\frac{1}{2}$ per cent.

To give ether successfully three points must be provided for: the evaporating surface must be large, the air inspired by the patient must pass across it, the supply of ether must be abundant so as not to require frequent renewal. The ordinary cone, with certain modifications, meets these wants very well. Three or four thicknesses of stout brown paper, or ten of newspaper, measuring twelve by fifteen inches, should be covered with a thick towel well pinned on, and rolled into the form of a cone, a foot long and five inches in diameter, and fastened with long pins. A hole should be left at the apex of the cone large enough to admit the little finger, and the corners at the base should be turned back. If the towel is thick it will hold all the ether that is needed, and if the base is pressed closely against the chin, cheeks, and nose, all the air breathed by the patient will have to enter by the hole left at the apex, and pass across the large evaporating surface of the inside of the cone. If the cone is held at first at a short distance from the mouth and then brought gradually nearer, complete anaesthesia may often be obtained in two or three minutes without having caused any strangling, or provoked any resistance.

Rectal Etherization. It was shown by Mollière, in 1884, that general anaesthesia could be readily obtained by the administration of ether by the rectum. The method was at once widely tried, but has been abandoned, except in special cases, for it was found to be more dangerous than the method by inhalation. The dangers are that the anaesthetization may unwittingly be made too profound and prolonged, and that the contact of the ether with the intestinal mucous membrane may cause a bloody diarrhoea.

The ether is placed in a bottle provided with a tightly-fitting cork through which passes a rubber tube. The free end of the tube is inserted in the rectum, and the bottle placed in warm water.

The precautions to be observed are that the water should not be warmer than 100° Fahr., and that as soon as anaesthesia is obtained the tube should be withdrawn from the rectum, to be reapplied if necessary. The tube should be large, and should extend downward from the anus to the bottle without loops or coils in which the ether might condense.

ARREST OF HEMORRHAGE.

Hemorrhage is arrested : (1) by ligature ; (2) by torsion ; (3) by pressure ; (4) by cold or heat ; (5) by position.

FIG. 1.



Artery forceps.

FIG. 2.

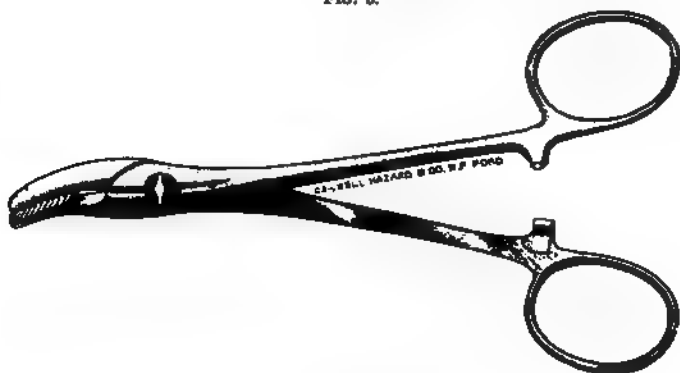


Self holding hemostatic forceps.

Ligature. The vessel or bleeding point is seized by forceps (Figs. 1, 2, and 3) with as little of the surrounding

tissue as possible. It is encircled by silk or catgut, which is tied in a square knot (Fig. 4). The portion distal to the ligature should be as small as possible.

FIG. 3.



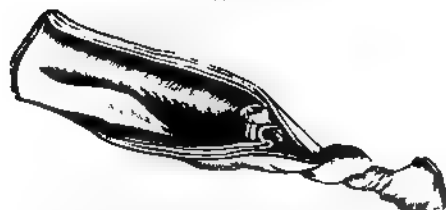
Self-holding hemostatic forceps; curved.

FIG. 4.



Square knot.

FIG. 5.



Effects of torsion upon the coats of an artery.

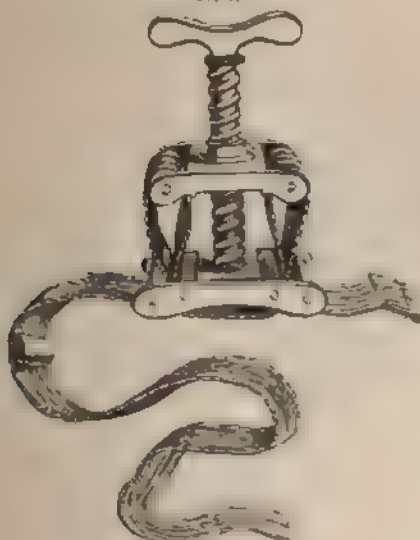
Torsion. The vessel is isolated, grasped by the forceps, drawn out, and twisted till it parts. It is not in general use except for small vessels. (Fig. 5.)

Pressure made by sponges, gauze pads, or clamps left in place for a few minutes will frequently be found sufficient to arrest oozing, venous hemorrhage, or the bleeding from small arteries.

Cold or Heat. Hemorrhage may be checked by the actual cautery at a dull-red heat; by ice-cold water; or by water at a temperature of 110° to 120° F.

Position, either alone or combined with pressure, is a valuable hemostatic. Elevation of a limb will diminish the blood pressure, and often allow a conglutium to form in some divided vessel where it would otherwise be washed away by the force of the blood flow.

FIG. 6.



Petit's tourniquet.

ARTIFICIAL ISCHEMIA.

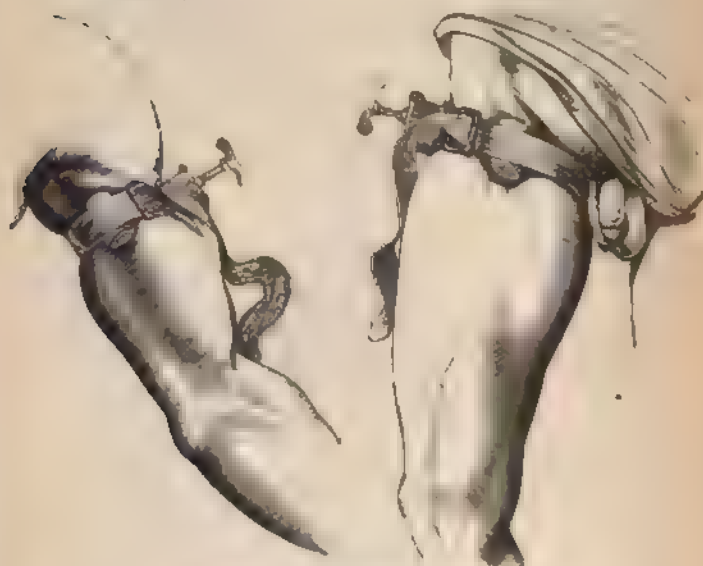
Loss of blood during an operation upon a limb may be prevented by pressure upon the main artery on the proxi-

mal side of the incision. This pressure may be made with the finger, tourniquet, or elastic cord.

The tourniquet (Fig. 6) is composed of a pad, band, and screw; by turning the screw the band may be tightened at will. The principle of its application is the compression of the artery against the underlying bone. A point should be selected in the course of the artery where such compression can be made; a roller bandage, an inch in diameter, placed over the vessel, and parallel to its course, the tourniquet then applied as shown in Figs. 7 and 8, and the screw

FIG. 7.

FIG. 8.



Mode of application of tourniquet

tightened. Some surgeons prefer to place the pad of the tourniquet upon the roller bandage itself, and not on one side as shown in the figure. The buckle on the band should always be much further from the roller than is represented in the figures.

The *elastic* tourniquet is applied by holding the limb for a short time in an elevated position to diminish the amount

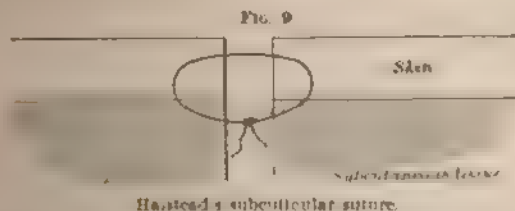
of blood in it. Then, without changing the position, a soft but stout rubber cord or band is wrapped several times about the limb sufficiently tight to occlude all the vessels, and fastened in position by a single knot. It should be applied at a convenient point, well above the seat of operation. Or the Esmarch rubber bandage, usually two or more inches broad, is applied from the fingers or toes of an extremity spirally upward, each upper turn overlapping the one below from a quarter to half an inch. It is wound tightly enough to completely empty all the vessels of blood as it advances, and is carried to the point where the rubber tourniquet can be best applied, which is then done as already described. The spiral bandage is then removed.

The objections to the rubber bandage and tourniquet are the possibility of pressure paralysis and the certainty of temporary vasomotor paralysis, with its consequent troublesome oozing. The advantages are that an operation can be performed upon the living body with as much ease and certainty as upon the cadaver. It is very useful whenever careful dissection is necessary.

Digital compression of the main artery of a part at a distance from the seat of operation is a useful temporary hemostatic. Amputations below the hip or shoulder can be satisfactorily performed by compression of the femoral artery against the os pubis or the brachial against the humerus.

SUTURES.

The interrupted suture is one in which each stitch is tied as it is made, and the knot drawn to one side of the inci-



sion. In Halstead's subcuticular method (Fig 9) the needle is introduced on the under surface of the skin on

one side, and brought out just beneath the cut edge, then entered in the reverse direction below the epidermic surface opposite; when knotted it will lie wholly out of sight.

The object is to avoid infection by the skin coccus (*staphylococcus epidermidis albus*). Fine silk must be used, and after a couple of weeks a small pimple will form over each stitch, and it will be quietly thrown off.

The *continuous suture* (Fig. 10) is passed in the same manner as the interrupted, but the stitches are not cut apart and tied. It is conveniently fastened at the last by

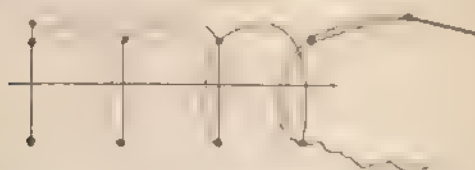
FIG 10



Continuous suture.

drawing it double through the last puncture and using the free end to make a knot with the double part attached to the needle. The needle each time, after emerging from the skin, may be looped under the immediately preceding and exposed portion of the suture (Fig. 11). This makes it resemble the interrupted suture in action.

FIG 11.



Continuous suture

The *twisted or figure-of-8 suture* (Fig. 12) is made by transfixing the lips of the incision with a pin (Figs. 13 and 14), about the two ends of which a thread is then twisted (Fig. 12).

FIG. 12.



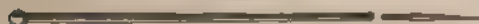
Twisted suture.

FIG. 13.



Harelip pin.

FIG. 14



Harelip pin with movable point.

Tension or relaxation suture is the name given to one employed to relieve strain on the sutures approximating the edges of the wound. The points of entry and emergence should be at a considerable distance from the incision. The thread is passed double, and in order to lessen the tension at any one point its extremities are tied over buttons or plates of lead or pads of gauze.

PREPARATION OF MATERIALS USED IN AN OPERATION.

Catgut ranges from the smallest size, No. 1, up to No. 6. It is first soaked in ether for twenty-four hours to free it from fat, then wound on glass spools which have been recently boiled. The hands which do the winding must be thoroughly scrubbed and disinfected, and during the winding the catgut must touch nothing which is not surgically clean. The catgut is then boiled in alcohol for one hour, and stored for use in boiled absolute alcohol in a sterilized glass vessel. The spools of catgut are sometimes soaked for twenty-four hours in a 1:1000 aqueous solution of bichloride of mercury before boiling.

Chromicized catgut is made by soaking for twenty-four to forty-eight hours 200 parts of catgut by weight in a mixture of carbolic acid, 200 parts, boiled water 2000 parts, and chromic acid 1 part. It is then boiled in alcohol and stored in boiled absolute alcohol.

Silk is used in sizes from the smallest, No. 1, to No. 18, the sizes most convenient for average use ranging from 7 to 10—No. 18 is suitable for large pedicles. It is wound on sterilized spools, boiled in water for half an hour, and stored in boiled absolute alcohol in a sterilized glass vessel.

Silkworm-gut is simply boiled in alcohol for one hour, and stored in boiled absolute alcohol in a sterilized glass vessel.

Sponges. Ordinary sponges are prepared as follows: Decalcify in a solution of one volume of commercial hydrochloric acid and three volumes of water. Examine each sponge separately for pieces of stone or coral, which must be cut or torn out. Then wash in running water to remove every particle of sand. Place them in a solution of permanganate of potassium of a strength of about 1 to 16 of water till they are stained a chestnut brown. Wash again in running water to remove the excess of permanganate. Place them in a solution of hyposulphite of soda and oxalic acid—about 5j of each to a pint of water, and stir the sponges till they are bleached. Then wash in running water to free from acid and precipitated sulphur. Rinse out in a solution of sodium bicarbonate—about 1 part to 25 of water. This neutralizes any acid and renders the sponge texture more absorbent. Wash again in sterilized water and store in a 1 : 20 carbolic solution.

Simple pads of sterilized absorbent gauze, with the margins loosely hemmed, make excellent and cheap sponges; they should be sterilized by steam for half an hour immediately before use.

Absorbent gauze is best purchased from the manufacturers. It should be cut into convenient lengths and sterilized by steam for half an hour immediately before use.

Bichloride gauze is conveniently made by wringing out the sterilized absorbent gauze in a solution of bichloride of mercury 1 part, common salt 1 part, and water 1000 parts. The salt prevents the bichloride from changing to calomel. It can then be sterilized by steam and kept in a sterilized tight vessel.

Iodoform Gauze. Where the exact proportion of iodoform is unimportant it can be made as follows: Sterilize a strip of absorbent gauze and the hands of the maker. Dissolve about 5j of castile soap in 3j of a 1:20 aqueous carbolic solution. Strain this through a piece of sterilized gauze to render the suds clear, and boil the filtrate. Mix this filtrate with nearly an equal part of iodoform in a sterilized basin. Again sterilize the hands and wring out the strip of sterilized gauze in this mixture. Store in a sterilized tightly-covered vessel in the dark.

Iodoform gauze containing 10 per cent of iodoform.

Ordinary absorbent gauze averages about an ounce in weight to the yard, and ten ounces of gauze will absorb about sixteen ounces of water. After sterilizing the hands, wring out nine yards of sterilized absorbent gauze in a mixture of sixteen ounces of boiled soapsuds with one ounce of iodoform, and store in the dark in an air-tight sterilized vessel.

The iodoform mixture cannot be boiled without decomposing the iodoform. The soapsuds cause the iodoform to mechanically adhere to the gauze. It is understood that the basin in which the mixing of the gauze, soapsuds, and iodoform is carried out has been cleaned and sterilized immediately previous to the process.

Some prefer to sterilize the prepared gauze by steam; but this sometimes decomposes part of the iodoform, and the iodine thus liberated is very irritating to the skin.

Drainage tubes are most conveniently made of ordinary rubber tubing—the red is the best—or of glass. These should be boiled and stored in boiled alcohol or 1:1000 bichloride solution, and immediately before use boiled again.

Absorbable bone drainage tubes are sometimes used. They can be obtained from the instrument makers.

Absorbent cotton is best purchased of the manufacturers. This and plain cotton can be sterilized by dry heat in an oven at 300° F. maintained for half an hour.

Rubber tissue is prepared by washing thoroughly in a 1:20 aqueous carbolic solution and soap. It is then washed in alcohol and stored in 1:1000 bichloride of mercury solution.

STERILIZATION.

The Arnold steam sterilizer is most efficient for general sterilization, although instruments are very apt to rust when subjected to this method of disinfection, in which steam is the sole agent. It is so constructed that the steam is condensed after it is used, and the water needs only infrequent renewal. Instruments must be treated in the Arnold sterilizer for about fifteen minutes, and other appliances and accessories (gowns, dressings, etc.) for from half an hour to three hours, according to the compactness of the bundle.

A very serviceable sterilizer can be made from an ordinary asparagus cooker—a covered tin vessel about twice as long as it is wide and deep—furnished with a removable tray. Instruments must be cleaned and then boiled for at least ten minutes after use, and again boiled immediately before another use in a 1 per cent. solution of sodium carbonate. The latter is a powerful disinfectant in boiling water, and, furthermore, helps to prevent rusting. After the instruments have been treated in the steam sterilizer or boiling water they should be placed in a tray containing a sterilized 1:10 carbolic solution, or in plain boiled and cooled water. Some surgeons prefer to wipe each instrument separately, after boiling, with a piece of sterilized cotton moistened with a 3 per cent solution of carbolic acid.

Articles such as roller bandages or gauze tightly packed in some vessel for transportation or storage cannot be rendered perfectly sterile throughout unless subjected to the action of steam under pressure for at least half an hour. A

somewhat expensive apparatus designed to meet this requirement is manufactured by the Sprague-Schuyler Company, of this city.

THE WOUND MADE BY THE SURGEON AND ITS TREATMENT.

The secret of success in operative surgery lies in absolute cleanliness of the operator and his assistants, the wound and its surrounding parts, of all instruments, dressings, and accessories, and of the room and its contents.

On the morning of the day before the operation the skin should be washed and scrubbed with green soap, shaved if necessary, and sponged off with a 1 : 1000 solution of bichloride of mercury. It is then spread with a layer of green soap, and covered with compresses saturated in the same material. Over this is placed a piece of rubber tissue to prevent drying, and the "soap poultice" is left in place till the evening before the operation, or for about twelve hours. It is then removed, and the area washed carefully with a 1 : 1000 bichloride solution, and a wet 1 : 5000 bichloride dressing applied and not removed till the patient is on the table—at least twelve hours later. The surface is then washed with ether, and again with the 1 : 1000 bichloride solution. The surgeon, his assistants, and any attendants in the operating-room should have their arms bare to the elbow, and wear sterilized gowns reaching to the feet. All these persons must thoroughly scrub with a sterilized brush, green soap, and hot water their arms, hands, and finger-nails. Then clean the finger-nails with a clean instrument and again scrub them. Rinse the hands and arms thoroughly in alcohol and soak them five minutes by the watch in a 1 : 1000 bichloride of mercury solution. If anything not previously sterilized is touched by any one in the course of the operation, the cleansing process must be repeated by that person.

The incision should be clean and smooth, and large enough to give plenty of room and permit easy recognition of all the parts as they are reached. If the operator attempt to work through too small an opening his manipu-

lations and efforts at retraction and clamping are liable to cause bruising of the margins of the wound. There must be no unnecessary or jagged cuts, which leave pedunculated masses of tissue to necrose. In order to minimize the amount of foreign material the ligatures should be as few and small as possible. Much of the hemorrhage can be stopped by simple pressure, as by clamps left in place for a few moments, or by packing with sponges or pads of gauze. Strong antiseptics and rough handling in a perfectly clean wound are to be avoided. After all bleeding has been checked, every portion of the wound surface should be brought into contact with some other, and held there immovably for from five to ten days. A well-applied dressing, aided by a few sutures, will generally be found sufficient for this purpose. Buried sutures should be used with caution. They unfavorably modify the nutrition of the parts, and thereby conduce to the development of such septic germs as may be present.

The question of drainage depends upon a number of considerations. A large effusion of blood or serum may be expected to follow some operations, and, by separating the apposed surfaces of the wound, prevent primary union. A well-applied dressing and sutures sufficiently far apart—half an inch to an inch—to allow the effusion to escape between them will generally suffice. This may be supplemented by a flat strip of sterilized rubber tissue introduced into the depths of the wound and brought out between the sutures. If spaces exist which cannot be obliterated, healing by the so-called organization of a blood clot can be attempted; or drainage may be practised as if infection were expected.

If it is thought necessary to use a drainage tube in an aseptic wound which remains so, the tube should be removed with every antiseptic precaution at the end of twenty-four to thirty-six hours. Pre-existing suppuration in the wound or its vicinity always calls for drainage. If suppuration occurs in a previously aseptic wound, every facility must be given for the escape of pus at the earliest moment. The whole wound may need to be laid wide open and packed with gauze. Pockets and dependent angles must be considered and counter-openings made if necessary.

An aseptic wound is closed by any suitable one of the different kinds of suture and covered with a strip of sterilized rubber tissue, over which is placed a layer of iodoform gauze, or the rubber tissue may be omitted. Apply next to the iodoform gauze compresses of sterilized absorbent gauze, dry, or wet in a 1:5000 solution of bichloride of mercury; cover these with sterilized absorbent cotton, which acts as a filter against germs coming from without, and also absorbs leakage from the wound. Bandage tightly enough to cause an even pressure and immobilization, and yet not interfere with circulation.

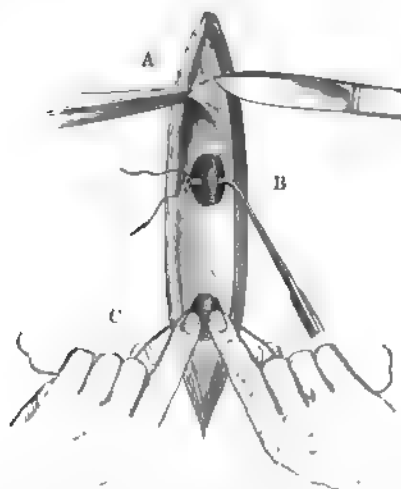
PART II.

LIGATURE OF THE ARTERIES.

GENERAL DIRECTIONS.

A POINT for the application of the ligature should be chosen, if possible, not nearer than half an inch to any collateral branch above or below it. The operator should

FIG. 15.



This diagram represents three distinct operations.
A. Opening the sheath. B. Drawing ligature round the artery.
C. Tying artery.

make himself thoroughly familiar with the anatomical relations of the parts and the landmarks of the operation; he should proceed methodically, in accordance with a definite

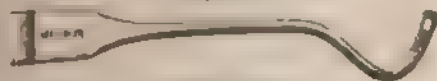
plan, and seek for and recognize each layer, each landmark in its order.

It is well to mark upon the skin with ink or iodine the line of the proposed incision: the incision should be free, and, so far as possible, its centre should correspond with the point at which the ligature is to be applied. The first incision should go fairly through the skin, and then be carried down to the enveloping fascia by repeated applications of the knife. The fascia should be pinched up, nicked, and divided upon a director if the vessels lie immediately below it, or upon the finger if a muscular interstice is to be sought for. The division of the fascia should equal in length the external incision.

The knife is then laid aside and the artery sought for by separating the tissues with the fingers or a director. The sheath is recognized by the communicated pulsation, and by the absence of the pinkish-white color and smooth shining surface which characterize the artery. When found, it is gently pinched up with the forceps, the flat of the knife laid upon it, and a hole one-quarter of an inch long carefully made in it. A distinct sheath is found only about the main trunks, and is replaced in the others by a layer of cellular tissue, which is more readily separated by tearing with the point of a director or with two forceps.

When the pinkish-white coat of the vessel has been fairly exposed, each edge of the hole in the sheath is grasped in turn with forceps, and the sides of the vessel gently separated from the sheath by tearing through the slight attachments with the point of a director.

FIG. 16.

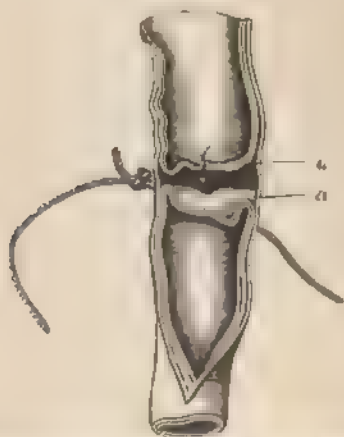


Aneurism needle.

A threaded aneurism needle is then entered on that side where the parts lie that are most to be avoided, and passed behind the artery, care being taken not to raise the latter from its bed, until its eye appears upon the other side; the thread is then picked up with forceps and drawn through while the needle is withdrawn. The precaution should never

be omitted of trying if compression of the vessel between the finger and the ligature arrests pulsation in its distal branches, for the best surgeons have mistaken a nerve or strip of fascia for the artery. The main trunks can be readily distinguished from the veins by their appearance—the veins resembling a leech, while the arteries are white and feel like a cord or band under the finger—and by their known anatomical relations; but it is often very difficult to recognize the smaller arteries, since they closely resemble the veins. The operator has to depend upon three indications: (1) the fact that when there are two satellite veins the artery is placed between them; (2) pulsation; (3) alternate compression of the vascular bundle at the two ends of the incision. Pressure at the proximal end causes the artery to shrink and the veins to swell; pressure at the distal end has the contrary effect.

FIG. 17.



a a. Inner coat of an artery ruptured by a ligature.

The ligature is then tied with a square knot (Fig. 4), tightly enough to cut the inner coats of the vessel, and one or both ends cut short, according to the material used. Aseptic catgut or silk should be used, both ends cut short, and the wound closed. The lymph thrown about these

ligatures gives strength to the wall of the vessel and additional security against secondary hemorrhage. Primary union, at least of the deep parts of the wound, may be confidently expected.

While making the incisions the position of the parts should be such that the muscles which serve as guides shall be tense, but while seeking for the artery the muscles should be relaxed so as to give more room.

ANATOMY OF THE SUPRA-CLAVICULAR REGION.

The superficial fascia underlies the platysma, and incloses the sterno-cleido-mastoid in a reduplication of itself. The middle, or sterno-clavicular, fascia has a common origin with the superficial fascia in the linea alba between the two sterno-thyroid muscles, divides into three layers to form sheaths for the sterno-thyroid and sterno-hyoid, unites, and again divides to form a sheath for the omo-hyoid, unites again and finally joins the superficial fascia between the trapezius and sterno-cleido-mastoid. This middle fascia is strong and resisting, and incloses all the vessels of the region except the external jugular vein, which is subcutaneous throughout its course until it turns inward to join the subclavian above the clavicle. These two fasciæ are separated from each other and from the skin by loose cellular tissue, in which a large amount of fat may be deposited, and it is of prime importance therefore that they should be recognized in the search for the vessels.

The vessels which are approached through this region are the innominate, the subclavian, and the common carotid. The bifurcation of the innominate corresponds with the sterno-clavicular articulation, and in old people, as well as in exceptional cases, rises from five to ten millimetres above it. It lies in front and on the right side of the trachea, and is crossed anteriorly by the left innominate vein. At the bifurcation the subclavian lies behind and to the outer side of the carotid, and is crossed by the pneumogastric and phrenic nerves close to its origin, the former giving off the recurrent laryngeal, which turns under the artery and rises again behind it. The carotid, which at first lies behind the

sterno-cleido-mastoid, soon reaches its anterior edge, and at the same time increases its distance from the trachea. While the internal jugular lies wholly within the middle-cervical fascia, the subclavian vein is enveloped by a reduplication of it and held closely against the clavicle thereby. It is therefore more superficial, and on a lower plane than the curved portion of the subclavian artery, and need not be uncovered in the search for the latter. The branches of the subclavian, seven in number, arise (with one exception, the transversalis colli) from its first portion, that comprised between its origin and the inner border of the scalenus anticus. The transversalis colli may arise from the first part, or the second (between the scalmi), or even the third (beyond the scalmi). The supra scapular crosses in front of the scalenus anticus and runs downward and outward to the clavicle, lying below the line of the incision made in tying the subclavian in its third portion.

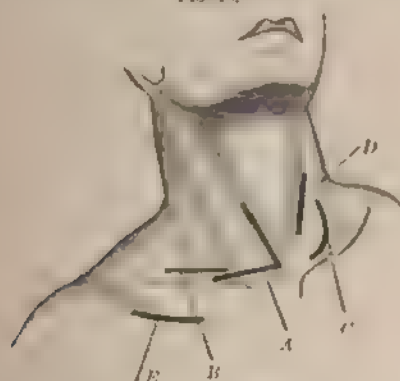
LIGATURE OF THE INNOMINATE ARTERY.

Anatomy. The artery is in relation in front with the innominate veins and the pneumogastric nerve; on the inner side with the trachea; on the outer side and behind with the pleura. It lies immediately behind the sterno-clavicular articulation.

Five different incisions have been proposed. A vertical one in the middle of the neck (King); a horizontal one $4\frac{1}{2}$ inches long, beginning in the middle line and passing outward parallel to and half an inch above the clavicle (Manc); an oblique one in the interval between the sternal and clavicular attachments of the sterno-cleido-mastoid (Sédillot); an oblique one from the anterior border of the left sterno-cleido-mastoid $2\frac{1}{2}$ inches above the clavicle down to and a little beyond the left sterno-clavicular articulation (Velpeau); a V-shaped one, of which one side lies over the anterior edge of the sterno-cleido-mastoid, and the other is parallel to and a little above the clavicle (Mott). The single incisions do not give sufficient room, and although they are more brilliant they should give way to the more prudent and practical one proposed by Mott.

Operation. An incision $3\frac{1}{2}$ inches in length is carried along the anterior edge of the right sterno-cleido-mastoid, ending half an inch above the sternum (Fig. 18 A). Another, of the same length, is carried outward from the lower end of the first, half an inch above and parallel to the right clavicle. These incisions are carried down to the superficial fascia, and the triangular flap between them dissected up. If the anterior jugular is encountered it must be drawn downward. The sternal and part of the clavicular attachments of the sterno-cleido-mastoid are now divided half an

FIG. 18.



Ligature of Arteries.

A. Innominate. B. Second or third portion of subclavian artery. C. Second or third portion of subclavian artery. D. Trachea, or anterior thyroid. E. Axillary below the clavicle.

inch above the bone on a director or with forceps and knife, and the muscle drawn upward and outward, uncovering the sterno-thyroid and sterno-hyoid and the middle cervical fascia, which here is very dense and covered by the inferior thyroid veins. The outer fibres of the sterno-hyoid and sterno-thyroid are now divided, the thyroid veins drawn aside, and the underlying or middle fascia torn through with the director, or opened very carefully with the knife. The common carotid is now seen at the bottom of the wound and traced downward to the innominate. The internal jugular is carefully pressed outward with a retractor; the

left forefinger, passed into the wound between the artery and the innominate veins, presses the latter against the sternum, and the operator proceeds carefully to clean the artery with a director half an inch below its bifurcation. The needle, guided by the finger, is passed from the outer side so as to avoid the vein, nerve, and pleura.

*Burdenheuer*¹ exposes the innominate by resection of a portion of the sternum. A transverse incision is made along the upper border of the sternum and inner third of the clavicle on both sides. Another incision is made in the median line at right angles to this from the larynx, well down upon the sternum. In the transverse incision the sterno-mastoid, sterno-hyoid, and sterno-thyroid muscles, and the deep fascia are cut through. The inner inch of the left clavicle and first rib are resected subperiosteally. By working inward through this gap the periosteum is freed from the posterior surface of the manubrium, and this bone is chiselled through transversely an inch below its upper border, and removed by cutting the right clavicle and first and second right ribs close to the sternal border. The periosteum is cut in the median line, the left innominate vein is pushed down and the right drawn to the right side, and the aneurism needle passed from right to left to avoid the pleura.

The innominate has been tied only for aneurism of itself, of the subclavian, or of the primitive carotid; but as it has been shown² that the treatment of aneurism by distal ligature yields satisfactory results, this operation is seldom justifiable. It may be rendered necessary by hemorrhage from the subclavian or carotid, but the attempt should always be made to tie the injured vessel in the wound before resorting to so dangerous a method as ligature of the innominata.

LIGATURE OF THE SUBCLAVIAN ARTERY.

The anatomical difference between the right and left subclavian is confined to the first portion of the artery, which

¹ *Deut. med. Woch.* vol. I., No. 40 p. 558.

² Dr. J. W. H. Van Buren, on Aneurism. Paper read before the International Medical Congress Philadelphia, 1876.

in the left is much longer, more vertical in its direction, and situated more posteriorly even than the innominate; a separate description therefore is required only for the first portion.

Operation. A V-shaped incision similar to that described for ligature of the innominate (Fig. 18) is made upon the left side, and carried through the sterno-cleido-mastoid and outer fibres of the sterno thyroid and sterno-hyoid muscles and the middle cervical fascia as before described. The carotid is then recognized, and, together with the internal jugular, drawn outward with a blunt hook. The muscles are now relaxed by bending the head and neck forward, and the cellular tissue torn through with forceps and director. The knife should no longer be used, on account of the risk of injury to the thoracic duct, which is imbedded in the loose tissue between the vessels and the vertebrae, and is rendered very difficult of recognition by its small size and thin walls. It runs directly across the route to the artery while passing from the bodies of the vertebrae to the anterior border of the scalenus anticus, and can best be avoided by making the search below and to the outer side of it in the lower angle of the wound.

The finger, passed downward and backward behind the carotid, soon feels the artery by pressing it against the side of the spinal column, the loose cellular tissue surrounding it is easily separated with the director, the vessel cleaned, and the needle passed from the inner side. The needle should have a short curve, and its point should be kept close against the vessel, so as to avoid injuring the pleura.

1st Portion. Right Subclavian. It is exposed in the same manner as the innominate artery, and the ligature passed from the outer side, the pneumo-gastric and phrenic nerves being pressed inward toward the carotid. The great danger of this operation lies in the proximity of collateral branches.

2d Portion. This operation, first proposed and performed by Dupuytren, is rendered dangerous by the fact that one, and sometimes several large branches are given off from this part of the artery. The preliminary steps are the same as those employed in ligature of the 3d portion; after

the middle cervical fascia has been divided, the tubercle of the first rib and the external border of the scalenus anticus are sought, the muscle bared and divided upon a director, the phrenic nerve which lies upon its anterior aspect being carefully avoided. As soon as the muscular fibres are cut they retract and leave the artery in full view.

3d Portion. Anatomy. The 3d portion of the subclavian lies between the outer border of the scalenus anticus and the tubercle of the first rib in front and the brachial plexus behind, and below the posterior belly of the omohyoid; it is crossed on a much more superficial plane by the external jugular, which enters the subclavian near the middle of the clavicle. In muscular subjects the clavicular insertions of the trapezius and sterno-cleido-mastoid muscles lie near to, or may even join, one another; in others they are from two to three inches apart. Ordinarily the vessel lies at a depth of one or one and a half inches below the surface, but in very fat persons, or when the clavicle has been pushed upward by an axillary aneurism, this distance may be increased to three inches.

Operation. Beginning an inch outside of the sterno-clavicular articulation, make an incision three or four inches long parallel to and half an inch above the clavicle (Fig. 18, B). Divide the skin and the platysma; when the external jugular is exposed draw it to the inner side or divide it between two ligatures. Divide on a director the superficial fascia, and the clavicular portion of the mastoid muscle if necessary, and seek the posterior belly of the omohyoid. Draw this muscle outward and upward, and feel for the tubercle of the first rib, following down the outer border of the scalenus anticus. Depress the shoulder as much as possible, denude the artery with the finger-nail or the point of a director, and pass the needle from below, taking care not to include the lowest bundle of the brachial plexus in the ligature. In order to avoid mistaking this bundle for the artery, the tubercle of the first rib should always be found; the artery lies against it, between it and the nerve.

Skey prefers, in difficult cases, a curved incision "commenced about two and a half or three inches above the clavicle, upon, or immediately on the outer edge of, the

mastoid muscle. This incision is carried slightly outward and downward, toward the acromion, and then curved inward along the clavicular origin of the mastoid muscle." (Fig. 18, C.) Ordinarily the external jugular is left to the outer side of the incision.

LIGATURE OF THE SUPERIOR THYROID ARTERY.

It arises close to the bifurcation of the common carotid at the upper border of the thyroid cartilage, and is in relation with the superior laryngeal nerve on its inner side.

Operation. A two-inch incision is made along the anterior border of the sterno-mastoid muscle, with its centre opposite the upper border of the thyroid cartilage. The skin fascia and platysma are divided, the sterno-mastoid drawn out, and the carotids recognized.

The superior thyroid artery will be found springing from the anterior surface of the external carotid close to the bifurcation of the common carotid artery. Pass the needle from above down, avoiding the superior laryngeal nerve.

LIGATURE OF THE INFERIOR THYROID.

Anatomy. After passing vertically upward, the artery curves inward to reach the under surface of the thyroid gland. The highest point of its curve is half an inch below the prominence on the transverse process of the sixth cervical vertebra, named by Chassaignac the *carotid tubercle*. In old people it is somewhat higher. It lies behind the common carotid and internal jugular, and is separated from them by more or less dense cellular tissue. The guides to the vessel are the carotid and Chassaignac's tubercle.

Operation. Make an incision three and a half or four inches in length along the anterior border of the sterno-cleido mastoid, ending an inch above the clavicle (Fig. 18, D). Lay bare the border of the muscle, and draw it outward, tear through or divide the middle fascia, and draw the carotid and internal jugular outward with a retractor. Flex the head slightly to relax the parts, feel with the finger

for the carotid tubercle, and seek the artery below it, separating the cellular tissue with a director. Pass the needle between the artery and vein.

Drobeck¹ makes an incision along the outer border of the sterno-mastoid muscle from the clavicle to the thyroid cartilage. The omohyoid muscle and, just below and parallel to it, the transversalis colli artery cross the wound transversely beneath the sterno-mastoid, and overlies the phrenic nerve as it passes vertically down on the scalenus anticus. At the inner border of the latter is the ascending cervical artery. The sterno-mastoid and great vessels are drawn toward the median line, and either the ascending cervical or transversalis colli artery is followed back to the thyroid axis. The inferior thyroid artery will be found at the inner side of the ascending cervical close to the inner border of the scalenus anticus just below the carotid tubercle. The recurrent laryngeal nerve lies still nearer the median line, and must not be included in the ligature, which should be passed from within outward.

LIGATURE OF THE VERTEBRAL ARTERY.

Anatomy. The vertebral artery passes from the first portion of the subclavian upward and backward to the transverse process of the sixth cervical vertebra. It is accompanied by a vein which lies in front, and is covered by the deep cervical fascia. The guide to it is the carotid tubercle.

Operation. The first incision is the same as for ligature of the inferior thyroid (Fig. 18, D). The anterior edge of the sterno-cleido-mastoid is exposed and drawn outward. The middle fascia is divided, and the carotid and jugular drawn inward. The gap between the longus colli and the scalenus anticus is then felt for about half an inch below the carotid tubercle, the deep fascia covering it torn through, the muscles separated, the vertebral vein pushed aside, and the artery exposed.

Chassaignac prefers an incision along the posterior border

¹ *Centralbl. für Chirurgie*, 1887, p. 592.

of the mastoid muscle, and reaches the carotid tubercle by drawing the muscle and vessels inward. If the muscle is very broad some of its clavicular fibres must be divided.

LIGATURE OF THE AXILLARY ARTERY.

Anatomy. The axillary extends from the middle of the clavicle to the lower edge of the tendon of the teres major. The axillary vein lies on the inner side and in front of it, and the brachial nerves invest its lower portion closely. It can be tied below the clavicle in the clavi-pectoral triangle formed by the clavicle, inner border of the pectoralis minor, and the thorax, or in the axilla. The strong fascia which unites the coracoid process and clavicle, and forms the suspensory ligament of the axilla, the costo-coracoid fascia, sends a prolongation about the upper portion of the axillary vein which keeps its walls from sinking in; the cephalic vein ascending in the groove between the deltoid and pectoralis major perforates this fascia and joins the axillary vein at the inner border of the tendon of the pectoralis minor, close by the origin of the acromial thoracic artery.

A. Ligature under the Clavicle (Fig. 18, E.) Make an incision extending from the summit of the coracoid process four or four and a half inches along the lower border of the clavicle. Divide successively the skin, subcutaneous tissue, superficial fascia, and pectoralis major, and then tear carefully through the costo-coracoid fascia, avoiding injury to the cephalic vein at the outer part of the wound. The pectoralis minor is now exposed, and after separating the cellular tissue with the point of a director the axillary vein is seen crossing from the upper edge of the muscle to the clavicle. The artery is completely hidden by it, lying on the outer side and a little behind. The vein must now be drawn inward, the needle entered between it and the artery, and the ligature applied as near as possible to the clavicle on account of the proximity of the acromial thoracic branch.

B. Ligature in the Axilla. *Anatomy.* The tissues and organs on the outer side of the axilla are arranged in the

following order: (1) the skin; (2) the subcutaneous cellular tissue; (3) the fascia; (4) the axillary vein; (5) the internal cutaneous and ulnar nerves; (6) the axillary artery; (7) the median nerve; (8) the coraco-brachialis; (9) the humerus and articular capsule. The old rule for exposing the artery here was to make a longitudinal incision at the junction of the anterior and middle thirds of the axilla, find the vein, count two nerves, and look for the artery just beyond the last one. This is a difficult and dangerous method, and a

FIG. 19.



A. Ligature of the axillary artery B. Ligature of the brachial artery

much simpler one has been substituted by Malgaigne, who was the first to point out that the coraco-brachialis muscle is the real guide to the artery.

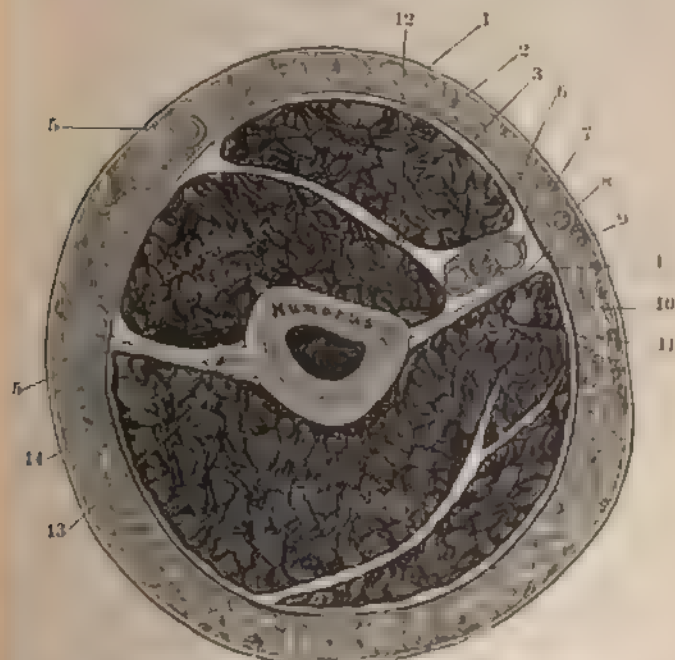
Operation. The arm is abducted completely, the incision commenced at the inner border of the coraco-brachialis over the head of the humerus and carried two and a half or three inches down the arm parallel to the course of the artery. It should involve the skin only, so as to avoid injury to the basilic vein. If the edge of the coraco-brachialis cannot be distinguished, the incision should be made according to the old rule, at the junction of the inner and middle thirds of the axilla. The aponeurosis is now divided upon a director over the coraco-brachialis, and the fibres of the inner border of this muscle exposed. The parts are then relaxed by bringing the arm nearer the trunk, and the posterior side of the wound, including the vein, ulnar and internal cutaneous nerves, is drawn back with a retractor; and the artery, overlain by the median nerve, usually ap-

pens at the bottom, covered, perhaps, by the posterior part of the sheath of the coraco-brachialis.

LIGATURE OF THE BRACHIAL ARTERY.

Anatomy. The brachial artery runs from the junction of the anterior and middle thirds of the axilla to the middle

FIG. 20.



Transverse section of the arm at its middle. FIG. 20.

1 Skin 2 Subcutaneous tissue 3 Enveloping aponeurosis 4 Aponeurosis separating the anterior and posterior groups in the inner side 5 Division on the outer side 6 Brachial artery and vein 7 Median nerve 8 Basilic vein 9 Internal cutaneous nerve 10 Ulnar nerve 11 Its artery and vein 12 Muscular cutaneous nerve 13 Muscular spiral nerve 14 Superior profunda artery 15 Cephalic vein

of the anterior aspect of the elbow. It occupies, when the forearm is supinated, the groove between the biceps and

triceps, being partly covered by the former in muscular subjects, and separated from the bone by the inner edge of the coraco-brachialis, and of the brachialis anticus. It lies in the anterior loge of the arm, which is bounded posteriorly on this side by a prolongation of the enveloping aponeurosis, extending down to the bone between the biceps in front and the triceps behind. It lies, consequently, within the sheath of the biceps, and the inner edge of this muscle is the sure guide to it. It lies between two satellite veins, which anastomose frequently, and has the median nerve in immediate relation with it on the side next the skin. The basilic vein directly overlies it between the skin and the aponeurosis. The artery presents frequent anomalies. The most common is its premature bifurcation into the radial and ulnar, which may take place as high as in the axilla, in which case one of the branches is superficial, perhaps even subcutaneous, while the other follows the usual course. The median nerve occupies the same sheath with the artery, lying first on the outer side and then crossing, in front or behind, very obliquely to the inner. The ulnar nerve, accompanied by an artery and two veins, lies in the substance of the triceps immediately behind the brachial artery and median nerve, separated from them only by the above-mentioned prolongation of the enveloping aponeurosis, and as they form a group differing from the other only in size, the artery may be mistaken for the brachial if met with (Fig. 20). This error will not be made if the fibres of the biceps alone are exposed and the incision confined to the anterior loge.

Operation Arm abducted, forearm supinated. Make an incision three inches long in the middle third of the arm, along the inner border of the biceps through the skin and subcutaneous cellular tissue, taking care not to injure the basilic vein, which should be kept posterior to the incision. Divide the aponeurosis and expose the fibres of the biceps. If the muscle is large draw it forward, and the sheath inclosing the artery, nerve, and veins will be disclosed. This is torn through carefully with a director, the median nerve separated and pushed aside, the artery separated from its veins, and the ligature passed from the side of the nerve.

FIG. 21.



Ligature of the brachial artery

LIGATURE OF THE RADIAL ARTERY.

Anatomy. The radial artery extends in a straight line from a point half an inch below the centre of the fold of the elbow to the ulnar side of the styloid process of the radius; it occupies the groove bounded on one side by the supinator longus, on the other by the pronator radii teres and flexor carpi radialis. It is covered only by the skin, cellular tissue, and aponeurosis; but in muscular subjects the muscular interstice in which it lies may be very deep. It is accompanied by two veins, and by no nerve. It occupies in its upper third the sheath of the pronator, and consequently the fibres of the supinator longus should not be exposed in the search for the artery, although the edge of the muscle may be taken as a guide to it. The radial nerve lies within the sheath of the supinator longus, and at first comes quite close to the artery; it then passes behind and to the outer side of the tendon of the muscle. It should not be seen during the operation.

Operation. *In the upper third* Make an incision two and one-half inches long in the line above mentioned, beginning one and one-half inches below the fold of the elbow. Avoiding the superficial veins, carry the incision through the cellular tissue. Recognize the edge of the supinator longus, and divide the aponeurosis along the ulnar side of it, exposing the fibres of the pronator. Press apart the two muscles if necessary, separate the artery from its veins, and pass the ligature.

In the lower third (Fig. 22). Make an incision in the above-mentioned line, if the position of the artery cannot be made out by its pulsations, two inches long, ending an inch above the wrist. Divide the skin and cellular tissue, and then the fascia carefully upon a director. Separate the artery from the two veins, and pass the ligature.

FIG. 22.



Ligature of the radial
and ulnar arteries.

LIGATURE OF THE ULNAR ARTERY.

Anatomy. In its first third the ulnar artery passes obliquely underneath the superficial layer of muscles, including the superficial flexor of the fingers to the inner side of the arm, where it becomes superficial, and lies between the flexor carpi ulnaris on the inside and the flexor sublimis digitorum on the outside. It then descends to the wrist in the direction of a line uniting the internal condyle of the humerus with the outer border of the pisiform bone. It is accompanied by two veins, and is joined by the ulnar nerve just before it becomes superficial, the nerve lying upon the inner or ulnar side of the artery. It may be tied at any point in the middle and lower thirds. As the deep and superficial flexors of the fingers are separated by a fascia, and as the artery lies below this fascia, it is covered in the lower part of its course by two distinct fasciæ, the enveloping fascia of the limb and this second one which unites the tendon of the flexor carpi ulnaris with those of the flexors.

Operation. At the junction of the upper and middle thirds. Beginning four finger-breadths below the internal condyle of the humerus make an incision three and one-half or four inches long in the line above mentioned (Fig. 22). Expose the enveloping fascia clearly, and, drawing back the posterior lip of the wound, seek the first muscular interstice in front of the ulna. It is that between the flexor

carpi ulnaris and the flexor sublimis digitorum, and can be recognized by the finger as a slight depression, or by the eye as a white line under the fascia. Divide the aponeurosis, beginning at the lower angle, where the space between the muscles is broadest, and then, instead of following the interstice directly backward, raise the flexor sublimis and advance transversely across the arm in the search for the artery which lies upon the deep flexor. Isolate the artery, and pass the needle from the side of the nerve.

In the lower third (Fig. 22). Make an incision slightly to the radial side of the tendon of the flexor carpi ulnaris, or in the line before mentioned, two inches long, and ending an inch above the end of the ulna. Divide the enveloping fascia upon a director, and tear through the second over the vessel, which can be seen and felt through it. Isolate the artery, and pass the needle from within outward so as to avoid the nerve.

LIGATURE OF THE COMMON CAROTID.

The place of election for ligature of the common carotid is just above the omohyoid muscle, but the lesion which renders the ligature necessary may require it to be applied at a much lower point. The vessel has been tied successfully at a point one-eighth of an inch from its origin at the bifurcation of the innominata.

The steps necessary to place a ligature upon the common carotid in the first part of its course are the same as for ligature of the first portion of the subclavian or of the innominata (*q. v.*). After the vessel has been exposed, the internal jugular is pressed to the outer side, the artery denuded, and the needle passed from the side of the vein.

At the place of election. The bifurcation of the common carotid is on a line with the upper border of the thyroid cartilage. The place of election for tying it is about three-quarters of an inch below its bifurcation. The guide to the artery is the anterior border of the sterno-cleido-mastoid muscle, and the danger is of wounding the jugular vein, which, when full, entirely covers the artery on the outer side.

Operation. Make along the anterior border of the sterno-cleido-mastoid an incision three inches in length, the centre of which corresponds with the crico-thyroid space (Fig. 23). Divide the skin, platysma, cellular tissue, and aponeurosis, and seek for the interstice between the sterno-cleido-mastoid and the sub-hyoid muscles. When found, the latter must be pressed inward, and the artery will appear at the edge of the sterno-cleido-mastoid, the vein, which is external to it, remaining covered. The artery is bared with a director, and the needle passed from without inward.

FIG. 23.



Ligature of the common carotid at the place of election

If, instead of pressing the trachea and its muscles inward, the mastoid is drawn outward, the vein is exposed, almost completely overlying the artery, and, by its presence and the necessity of handling it, increases the difficulty and danger of the operation.

LIGATURE OF THE EXTERNAL CAROTID.

The free anastomoses which exist within the cranium between the two internal carotids render ligature of the common carotid insufficient to arrest hemorrhage from the

external carotid: the ligature must be applied to the vessel itself, despite the number of its branches and the difficulty of recognizing them at the bottom of the incision. The operation is a difficult one, for there are many important organs to be avoided, and there is no direct guide to the vessel.

Anatomy. The common carotid divides opposite the upper border of the thyroid cartilage (a little lower in females) into the external and internal carotids, which occupy nearly the same antero-posterior plane, the former being in front. At about three-quarters of an inch above the bifurcation the arteries cross, the external becoming posterior, the internal anterior. The internal carotid gives off no branches outside the cranium, while the external gives off eight. Of these the superior thyroid arises at or very near the bifurcation, the lingual, facial, ascending pharyngeal, and occipital near the point where the artery passes under the digastric, about an inch above the bifurcation, the others at a considerable distance above. The hypoglossal nerve looping around the occipital artery at its origin crosses the external carotid to the hyoid bone, sending a branch, the *descendens noni*, down the outside of the artery.

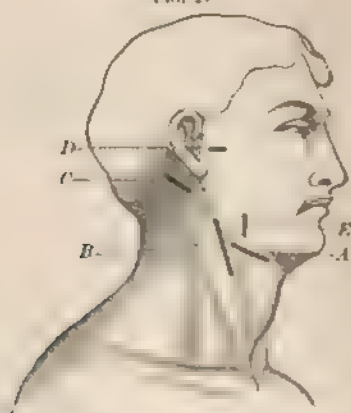
There are thus three means of distinguishing the external carotid: (1) its branches; (2) its position with reference to the internal carotid; (3) its immediate relations with the hypoglossal nerve, the internal carotid occupying a deeper plane. In a search for the external carotid the operator may be satisfied with either of these guides, accordingly as one or the other presents itself. Should the nerve be first encountered, he will tie the vessel upon which it lies; should both vessels lie at the bottom of the incision, he will know that the anterior one is the external carotid; and if the vessel which he isolates has a branch, he knows it cannot be the internal carotid.

Although the force of the objection has been greatly diminished by the employment of antiseptic silk or catgut ligatures, which admit of primary union throughout the wound, it is still desirable that the ligature should be applied at a distance from branches of considerable size; and from this point of view the first half-inch of the artery and the portion underlying the digastric are the places of elec-

tion, and of these two the former alone is practicable. The connective tissue surrounding the two arteries at their origin is, however, unusually compact, rendering their denudation so difficult that any search for branches would be dangerous to the nutrition of the vessel's wall.

M. Guyon¹ has shown that, while the lingual and superior thyroid arteries vary greatly in their points of origin, the average distance between them is from 12 to 18 millimetres, or over half an inch; he calls the portion of the vessel between them the "trunk of the external carotid," and suggests that the ligature should be applied 6 mm. below the point at which the hypoglossal nerve crosses the artery, this nerve being, in the great majority of cases, in immediate relation with the origin of the lingual artery. Dolbeau, in his report upon this paper, advises that the superior thyroid should also be tied, and that the carotid should be sought for from below upward instead of from above downward, on account of the greater depth of its upper portion and

FIG. 24



Ligature of A Lingual artery. B External carotid C Occipital
D Temporal E Facial

the supposition of large veins. M. Guyon collected twenty-four cases of ligature of the external carotid without espe-

¹ Mémoires de la Soc. de Chirurgie 1864, p. 555.

cial reference to the proximity of branches, and in only one of them did secondary hemorrhage occur.

Operation. When the head is extended and the face turned to the opposite side, an incision carried from the angle of the jaw to the anterior border of the sterno-cleido-mastoid opposite the top of the thyroid cartilage will cross the artery obliquely (Fig. 24, *B*). It must be carried through the skin, platysma, and subcutaneous cellular tissue, the external jugular being drawn aside when encountered. The superficial fascia is then divided in the line of the incision, care being taken not to deviate to the right or left, and the deeper and denser layer then torn through with the director. When the artery has been exposed and cleaned, the needle is passed from behind forward.

The lymphatic glands of the region are numerous and often large, and may be mistaken for the artery. There is no objection to removing any that may interfere with the search for the vessel.

LIGATURE OF THE INTERNAL CAROTID.

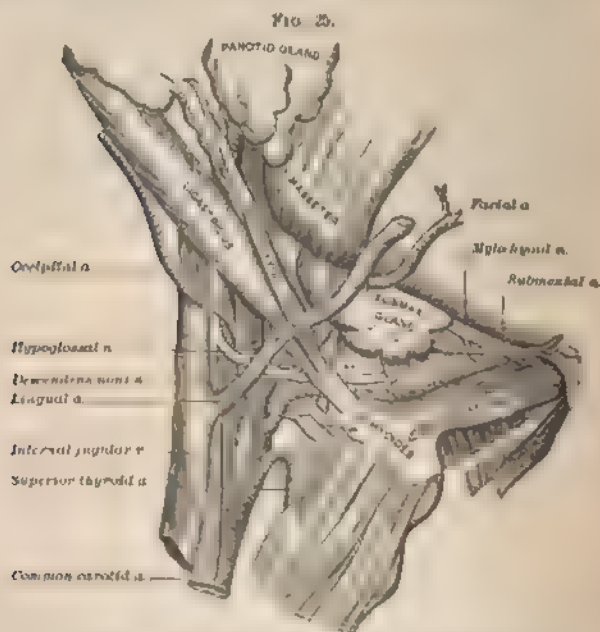
This is to be done according to the method described for the external carotid.

LIGATURE OF THE LINGUAL ARTERY.

Anatomy. The lingual artery arises from the external carotid, on a level with the great horn of the hyoid bone, and passes between the middle constrictor of the pharynx and the hyoglossus upward and forward. It is occasionally accompanied by a small vein, but the lingual vein is separated from it by the thickness of the hyoglossus muscle. Its one important branch, the sublingual, sometimes has its origin at or near the point where the lingual is usually tied, and may be mistaken for it. The artery may be tied near its origin, between the great horn of the hyoid bone and the posterior belly of the digastric, but its depth at this point, and the presence of large veins, make the operation difficult and dangerous. The place of election is in the

triangle bounded posteriorly by the posterior belly of the digastric, anteriorly by the posterior border of the mylohyoid, and above by the hypoglossal nerve. It is covered at this point by the skin, platysma, cervical aponeurosis, submaxillary gland, and the hyoglossus muscle, the fibres of which form the floor of the triangle just described.

Operation. Make a curved incision two inches long, its concavity directed upward, its centre one-quarter of an inch



Anatomical relations of the lingual and facial arteries

above the hyoid bone at a point midway between the median line and the extremity of the great horn (Fig. 24, A). Divide the skin and platysma, pushing the superficial veins aside, and then the cervical aponeurosis, which may be very thin. Raise the submaxillary gland, find the posterior belly of the digastric, its attachment to the hyoid bone, the posterior border of the mylohyoid, and the hypoglossal nerve accompanied by the lingual vein. Draw the hyoid bone

slightly downward with a blunt hook fixed in the lower angle of the triangle bounded by these organs, and then, pinching up the fibres of the hyoglossus with a pair of forceps, divide them carefully along a line parallel to the nerve, and midway between it and the bone. As the cut fibres retract, the artery is disclosed below them; separate it from its vein, if there be one, and pass the ligature.

LIGATURE OF THE FACIAL ARTERY.

The facial artery crosses the inferior maxilla just in front of the anterior edge of the masseter, from which it is separated by the facial vein (Fig. 25). A depression, in which it is lodged, can usually be felt on the lower edge of the bone. The artery can be exposed by a vertical incision along its course, or by a horizontal one along the lower border of the maxilla.

Operation (Fig. 24, E). Beginning at the lower edge of the maxilla, make an incision one inch in length along the course of the artery; divide the skin, subcutaneous tissue, and fascia; separate the artery from the vein and pass the needle between them.

If the horizontal incision is used, it should extend three-quarters of an inch on each side of the artery, the anterior edge of the masseter should be recognized, and the vessel sought for immediately in front of it.

LIGATURE OF THE OCCIPITAL ARTERY.

At the Mastoid Process. The guides to the vessel are the apex and posterior border of the mastoid process, the digastric groove on its inner surface, and the digastric muscle.

Operation (Fig. 24, C). Starting from a point half an inch below and in front of the apex of the mastoid process, carry the incision two inches obliquely backward parallel to the border of this process. Divide the skin and enveloping fascia, and then the sterno-mastoid and its insertion throughout the entire length of the incision. Then divide the splenius and its shining aponeurosis, and feel for the digastric

groove. Pinch up and carefully divide a thin fascia which covers the anterior face of the splenius. Starting from the belly of the digastric, separate the cellular tissue in the anterior angle of the wound with a director, denude the artery and tie. (*Chauvel.*)

LIGATURE OF THE TEMPORAL ARTERY.

(Fig. 24, D.) Make a transverse incision one inch long, extending from the tragus of the ear forward over the zygomatic arch. Separate the subcutaneous cellular tissue, which is very dense and fibrous, with a director, and seek the artery imbedded in it about a quarter of an inch in front of the ear. Press the vein backward, pass the needle from behind forward, taking care not to include in the ligature the temporal branch of the auriculo-temporal nerve, which is sometimes in close relations with the artery.

LIGATURE OF THE ABDOMINAL AORTA.

This operation has been performed about a dozen times, with a fatal result in each case. The patients survived for periods varying from a few hours to ten days. The artery may be reached through the abdominal cavity by an incision in the median line, or, without dividing the peritoneum, by an incision in the flank similar to König's for extirpation of the kidney (*q. v.*). The objection to the former is the danger consequent upon exposure of the peritoneal sac and its contents, but the steadily improving results of abdominal surgery show that this is not exceptionally great. On the other hand, the application of a ligature, even under the most favorable circumstances, after the artery has been exposed by the other method, requires the utmost dexterity, the chance of exciting peritonitis is great, and, finally, the presence of the aneurism and the displacements and adhesions it has caused may render it impossible to reach the vessel.

Operation Through the Peritoneal Cavity. An incision in the linea alba, extending from a point three inches above

the umbilicus to one three inches below it, and curving to one side to avoid the umbilicus. Divide the peritoneum upon a director, press the intestines aside, tear through the peritoneum covering the aorta with the finger-nail, separate the nerves from its anterior surface, and pass the ligature from the outer side. Cut both ends short, and close the external wound as in ovariectomy.

LIGATURE OF THE COMMON ILIAC.

Anatomy of the Common, Internal, and External Iliac Arteries. The aorta bifurcates usually on the left side of the fourth lumbar vertebra, and the direction of the common and external iliacs is represented by a line drawn from a point an inch above the umbilicus to another one-half an inch external to the centre of Poupart's ligament. The common iliac is usually two inches long, and bifurcates at the sacro-iliac synchondrosis, but it must be remembered that this bifurcation may take place at any point between one and a half and three or even four inches from the origin of the artery. The common iliac gives off no branches.

The external iliac runs downward and outward along the brim of the pelvis from the bifurcation to a point under Poupart's ligament midway between the anterior superior spine of the ilium and the symphysis pubis. Its two branches, the epigastric and circumflex ilii, are given off nearly opposite each other, a short distance above Poupart's ligament, sometimes much higher.

The internal iliac runs downward and backward into the pelvis for one and a half inches, dividing at the upper border of the great sacro-sciatic foramen into two large trunks. The ureter crosses the vessels at or just below the bifurcation of the common iliac, the vas deferens two and a half or three inches lower. Both are more closely adherent to the peritoneum than to the arteries. The iliac veins lie upon the inner side and posterior to the arteries; both pass behind the right common iliac, the right vein at its bifurcation, the left vein much higher up. The spermatic vessels and genito-crural nerve lie in front of the external iliac

at the lower part of its course, and the circumflex iliac vein crosses it at the same place.

The abdominal wall at the point where the incisions are made is composed of the following layers in the order named: skin, subcutaneous cellular tissue, fascia, external oblique or its aponeurosis, internal oblique, transversalis, and transversalis fascia.

Extra-peritoneal Operation. Beginning at a point a finger's breadth above Poupart's ligament and just outside of the external iliac artery, make an incision four, five, or six inches in length, according to the thickness of the abdominal wall, parallel at first to Poupart's ligament, and curving upward after passing the anterior superior spine of the ilium (Fig. 26). Divide the skin, subcutaneous tissue,

FIG. 26



Ligature of A Common iliac B External iliac
C Femoral in Scarpa's space

and fascia, exposing the aponeurosis of the external oblique; divide the latter upon a director throughout the whole extent of the incision, and then divide the fibres of the internal oblique and transversalis in the same manner, or by pinching them up with the forceps and cutting carefully with repeated slight touches of the knife, until the fascia transversalis, which varies much in density, is exposed. Raise the fascia at the lower angle of the wound, where it is most dense, with forceps, and make a hole in it large enough to admit the finger. Pass the forefinger through

this hole, press back the peritoneum with it, and enlarge the hole upward in the line and to the full extent of the incision, the finger being kept between the peritoneum and the knife.

The peritoneum is now raised from the psoas and iliacus muscles and drawn upward and inward by an assistant, while the operator seeks for the external iliac and passes the forefinger of his left hand along it to the common iliac, the thighs being flexed to relax the abdominal walls. As it is seldom that a good view of the artery can be obtained, the finger must be kept upon it, and the loose cellular tissue in which it is imbedded very gently separated with the point of a director or the finger-nail. When the artery has been properly cleaned, pass the needle from within outward.

Intra-peritoneal Operation. Open the abdomen in the median line by an incision extending from the symphysis pubis to or a little above the umbilicus, and, after pushing aside the intestines with flat sponges or pads, tear through the peritoneum overlying the artery and pass the ligature from within outward.

Care must be taken not to include the ureter, which usually crosses the vessel at its point of bifurcation. In the extra-peritoneal operation there is less danger of this accident, as the ureter is adherent to the peritoneum, and is lifted out of the way as this membrane is stripped up.

LIGATURE OF THE INTERNAL ILIAC.

Its accompanying vein lies behind and on the inner side.

Extra-peritoneal Operation. Same as for ligature of the common iliac. After the peritoneum has been lifted up, the finger is passed along the external iliac to the bifurcation, and then downward for half an inch along the internal iliac. The vein being carefully protected, the artery is bared, and the ligature passed from within outward.

The *intra-peritoneal operation*¹ does not differ enough

¹ Dr. F. A. Fenwick discusses this operation in its application to spontaneous gluteal and sciatic aneurisms in the Medical News, Nov. 26, 1896.

from that for tying the common iliac to require a separate description.

Ligature of the internal iliac has been seldom employed, except for traumatic gluteal aneurism, and in these cases, as Professor Van Buren¹ has pointed out, the treatment should be to cut down upon the sac, and tie both ends of the artery, hemorrhage being controlled by digital pressure made upon the internal iliac from within the rectum.

LIGATURE OF THE EXTERNAL ILIAC.

Various cutaneous incisions have been recommended for this operation. Sir Astley Cooper's extended from the external abdominal ring to within a short distance of the superior spine of the ilium; the objections to it are that it involves the division of the superficial epigastric, and, perhaps, of the internal epigastric also, and that the ligature can be applied only to the lower part of the artery. Abernethy's extended outward from the internal inguinal ring parallel to Poupart's ligament; by it the vessel is reached at a greater depth, but it has the great advantage of allowing extension, so that if it should prove necessary the ligature may be applied even to the common iliac. By curving the outer portion of the incision upward away from the superior spine of the ilium, the main branches of the circumflex ilii may be avoided.

Operation. Beginning over the outer side of the artery a finger's breadth above Poupart's ligament, make an incision three or four inches in length, at first parallel with Poupart's ligament, and then curving upward (Fig. 26). Carry this incision through the abdominal wall, and raise the peritoneum from the surface of the iliacus and psoas muscles in the same manner as for ligature of the common iliac. Flex the thighs so as to relax the abdominal muscles, and, while an assistant draws the peritoneum and the contained intestines upward and inward, seek the artery upon the inner border of the psoas. Clean it with a director or pair of forceps, and pass the needle from within outward.

For the intra-peritoneal operation an incision along the

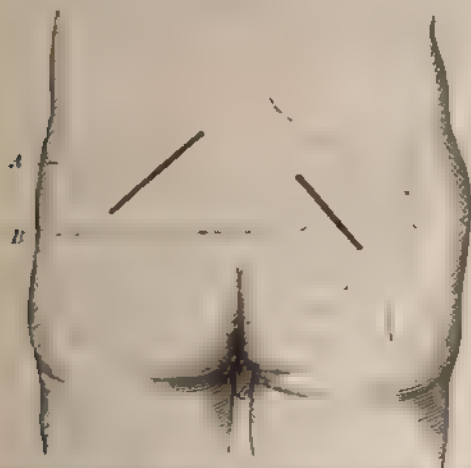
¹ Report on "Aneurism," Proceedings of the International Medical Congress, 1874.

lower part of the linea semilunaris would generally be better than one in the median line.

LIGATURE OF THE GLUTEAL, SCIATIC, AND INTERNAL PUDIC ARTERIES.

The proper treatment of injury to either of these arteries is to enlarge the wound and tie both ends of the divided vessel, but it may happen that this would be impossible,

FIG. 27



Ligature of - A Gluteal artery B Sciatic and internal pudic

and that ligature in continuity is required. The necessary incisions are those shown in Fig. 27. The place at which the gluteal artery emerges from the great sciatic notch may be roughly stated as opposite a point at the junction of the upper and middle thirds of a line joining the posterior superior spine of the ilium with the great trochanter.

The sciatic, where it crosses the spine of the ischium, lies opposite the junction of the middle and lower thirds of a line joining the tuberosity with the posterior superior spine of the ilium.

After division of the skin and fascia, the fibres of the

gluteus maximus are separated and held apart with long retractors, the deep fascia torn through, and the artery sought for.

The *gluteal artery* is to be sought for above the pyriformis muscle at the upper border of the great sacro-sciatic notch, where it can be felt near a small bony tubercle. It is covered by many large veins, which require very careful handling. The ligature should be applied as close to the notch as possible.

The *sciatic* and *internal pudic* arteries leave the great sciatic notch at the lower edge of the pyriformis; the former divides almost immediately, the latter re-enters the pelvis through the lesser sacro-sciatic notch, lying on the inner side of the sciatic artery during its passage over the spine of the ischium.

LIGATURE OF THE FEMORAL ARTERY.

Anatomy. The femoral artery is the continuation of the external iliac, and extends in a straight line from a point midway between the anterior superior spine of the ilium and the symphysis pubis to the ring in the tendon of the adductor magnus about four finger-breadths above the tubercle of insertion of that muscle on the upper portion of the inner condyle of the femur. In the first one or two inches of its course it gives off the superficial external pudic, epigastric, and circumflex ilii, and the much larger and more important profunda arteries. The anastomotica magna arises near its lower end. The artery is accompanied throughout by the femoral vein, which, at first, lies upon the inner side, and then becomes posterior. They are separated at first by a distinct septum, which disappears in the lower third. The anterior crural nerve emerges from below Poupart's ligament, about half an inch external to the artery; it divides up rapidly, and one of its branches, the internal or long saphenous, enters the sheath of the vessels three or four inches below the groin, and leaves it again after the artery has entered Hunter's canal; this name being given to the condensed sheath for a short distance above and below the point where it passes through the tendon of the adduc-

tor magnus. The artery passes under the sartorius at about the junction of its upper and middle thirds.

Ligature of the femoral above the origin of the profunda has proved unsatisfactory, and has been generally abandoned for that of the external iliac. The artery may be tied at any part of its course, but the point generally chosen is at the apex of Scarpa's triangle, next that in the middle of the thigh, and, lastly, in Hunter's canal.

Operation. A. *At the Apex of Scarpa's Triangle* (Figs. 26 and 28). Make an incision three or four inches long,

FIG. 28.



Ligature of the femoral artery

the centre of which shall be a little above the point where the inner border of the sartorius crosses a line drawn from the middle of Poupart's ligament to the inner tuberosity of the femur. The internal saphenous vein should be out of danger on the inner side of the incision. Divide the skin, subcutaneous tissue, and the fascia lata, exposing the fibres of the sartorius, which may be recognized by their direction downward and inward, those of the adductors, on the contrary, being downward and outward. The limb should now be slightly flexed, the vessels recognized by the touch at the inner border of the sartorius, this muscle drawn outward, and the sheath of the vessels pinched up with forceps on the outer side (the vein lying on the inner) and opened. The needle is then passed from within outward.

B. *In the Middle of the Thigh.* Here the vessel lies underneath the sartorius which overlaps it on both sides.

The incision is made in the line above mentioned, its centre being a little above the middle of the thigh; the sartorius is exposed and drawn outward after the leg has been further flexed. The vessel is then sought for, exposed, and tied as before.

C. In Hunter's Canal. Abduct and flex the thigh, and rotate it outward so as to make the adductors tense; feel for the tendon of the adductor magnus and make an incision three or four inches long, the centre of which is at the junction of the lower and middle thirds of the thigh, in the direction of the tendon, which is that of a line drawn from the spine of the pubis to the tubercle on the inner condyle of the femur. Divide the skin and subcutaneous tissue carefully so as not to wound the internal saphenous vein, and then the aponeurosis upon a director. Recognize the fibres of the sartorius and of the vastus internus which are at right angles with one another, and by pressing the former inward or the latter outward the tendon of the adductor and the curved glistening fibres arching from it to the vastus internus are exposed. If the saphenous nerve is now encountered it should be traced upward, a director passed into the orifice through which it emerges, and the aponeurosis divided upward; if the nerve is not seen it should not be sought for, but the aponeurosis should be pinched up and divided close to the tendon of the adductor. The sheath of the vessels is now opened, and the artery is separated from the closely adherent vein. The needle should be passed from within outward.

Some surgeons prefer to make the first incision in the direction of the artery rather than in that of the tendon.

LIGATURE OF THE POPLITEAL ARTERY.

This is an operation which is required only in the rare cases of rupture of the artery when an attempt is to be made to save the limb. The artery lies very deep between the condyles of the femur, imbedded in fat, and directly covered by the vein, the walls of which are thick and stiff like those of an artery. The short saphenous vein perfor-

ates the fascia near the centre of the popliteal space, and empties into the main trunk.

Operation. Make an incision three or four inches long in the vertical diameter of the popliteal space, the centre of which shall correspond to the point at which the ligature is to be placed. Divide the skin and cellular tissue, taking care not to injure the saphenous vein, and then the aponeurosis to the full extent of the cutaneous incision. Flex the leg, have the sides of the wound drawn widely apart, and work down through the fat and lymphatic glands to the artery, leaving first the nerve and then the vein upon the outer side. Protecting the vein with one finger, denude the artery and pass the needle from without inward.

Jobert (de Lamballe) reached the popliteal artery in the upper part of its course by an incision on the inner aspect of the leg, passing between the tendon of the adductor magnus on one side, and the sartorius, semi-membranosus, and semi-tendinosus on the other. The artery is found lying close to the femur.

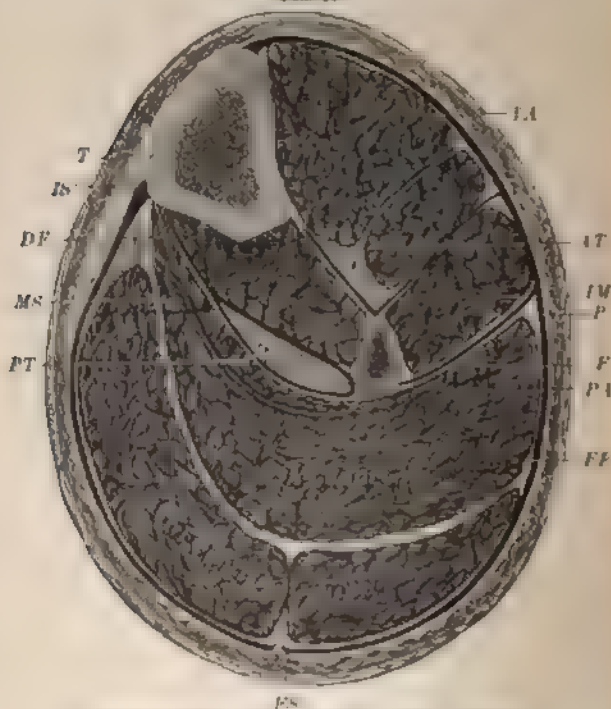
LIGATURE OF THE ANTERIOR TIBIAL ARTERY.

Anatomy. After perforating the interosseous membrane at the upper part of the leg, the anterior tibial runs in a direction which is that of a line drawn upon the anterior aspect of the leg from the upper tibio-fibular articulation to a point midway between the malleoli. It lies at first between the belly of the tibialis anticus and that of the extensor communis digitorum upon the interosseous membrane, afterward between the tibialis anticus and the extensor proprius pollicis or their tendons upon the tibia. It is accompanied by two veins and the anterior tibial nerve, which latter lies first upon the outer side and then crosses in front to the inner side. It may be tied at any point in its course.

Operation. Make in the above-mentioned line an incision the length of which will vary according to the depth at which the artery is placed. Divide the skin and cellular tissue, lay bare the fascia, and divide it along the first muscular interstice, which shows as a white line under it; make

also a transverse incision through the fascia from the middle of the longitudinal one to the crest of the tibia, so as to give more room. Flex the foot upon the leg, separate the

FIG. 29



Transverse section of the leg, upper third. (TITMUS.)

T Tibia F Fibula DF Enveloping fascia DF Deep fascia dividing to enclose PT Posterior tibial artery and nerve and PA Peroneal artery TA Tibio-tarsal muscle AT Anterior tibial artery and nerve IM Interosseous membrane P Peroneus longus muscle IS Internal saphenous vein ES External saphenous vein and nerve

muscles from below upward with the finger, draw them apart with retractors, isolate the artery without raising it, and pass the needle from the side of the nerve.

LIGATURE OF THE DORSALIS PEDIS.

This artery is the continuation of the anterior tibial, and passes through the posterior end of the first metatarsal space to the plantar aspect of the foot. It lies on the outer side of the tendon of the extensor proprius pollicis, and is crossed in its lower portion by the inner tendon of the extensor brevis. It is covered by the skin, superficial fascia, the edge of the extensor brevis, or its tendon, and a deep fascia. Its direction is that of a line drawn from a point midway between the malleoli to the posterior end of the first metatarsal space. The incision should be in this line, and the tendon of the extensor proprius pollicis should be left on the inner side.

LIGATURE OF THE POSTERIOR TIBIAL.

The posterior tibial artery in its upper and middle portions lies upon the tibialis posticus and the flexor communis digitorum, and is covered by the soleus, from which it is separated by the deep fascia. Near the ankle it is covered only by the integument and fascia. In its upper portion it can be reached by two routes: (1) the one employed by Guthrie, and approved of by Spence and Holmes, through the middle of the calf; (2) the one in more common use, from the inner side of the calf.

Operation (Guthrie). Beginning at the lower angle of the popliteal space, make an incision six inches in length directly downward, avoiding as far as possible the superficial veins, carry this incision through the soleus, divide the deep fascia, separate the artery from the vein and nerve, which are superficial to it, and pass the needle from their side.

Lateral Method. Beginning in the middle of the upper third of the leg, make an incision from four to five inches long, parallel to and half an inch behind the inner border of the tibia. Carry the incision down to the fascia, leaving the internal saphena on the tibial side: divide the fascia, draw the gastrocnemius backward, and separate the soleus

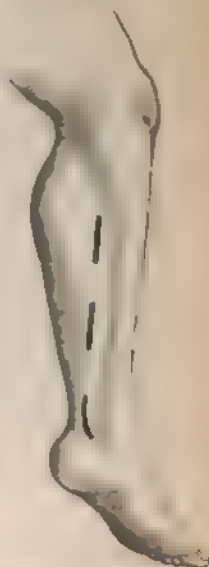
at its attachment to the tibia, leaving the deep fascia attached to the bone. Raise the heel and flex the leg upon the thigh, draw back the calf, enlarge the incision if necessary, seek the artery and tear carefully through the deep fascia over it; isolate the artery, leaving the nerve on the outer side, and pass the needle between. 'Tillaux' has proposed a modification. Instead of detaching the soleus from the tibia, he

FIG. 30.



Ligature of the anterior tibial artery

FIG. 31.



Ligature of the posterior tibial artery

passes between it and the gastrocnemius, and then divides the former muscle longitudinally over the course of the artery. If this incision does not at once expose the artery, the vessel must be sought for on one side or the other by pressing back the sides of the incision.

The centre of the soleus is occupied by an intra-muscular septum parallel to the deep fascia, and sometimes so stout

¹ *Anatomie Topographique*, Paris, 1877, p. 1143.

as to be mistaken for it. Close attention is required for the avoidance of this error.

In the Lower Third and Behind the Ankle. The artery lies midway between the tendo Achillis and the inner edge of the tibia or the malleolus, and is covered by the superficial and deep fasciæ, the latter of which forms the annular ligament at the ankle.

Operation. Midway between the tendo Achillis and inner edge of the tibia, or a finger's breadth behind the latter, make an incision three inches long parallel to the tibia, if the ligature is to be placed above the ankle, or a curved line parallel to the posterior border of the malleolus, if it is to be placed behind the ankle. Seek the bundle of vessels, tear through the deep fascia covering them, taking care not to open the tendinous sheaths which lie in front, and pass the needle from without inward.

PART III.

AMPUTATIONS.

AMPUTATIONS may be in *continuity* (through the bone), or in *contiguity* (through a joint); to the latter the term *disarticulation* is usually applied. The methods of operation are classified as *circular*, *oval*, and *flap*, and the choice of a method is determined by the disposition of the soft parts about the bone, the facility with which the joint can be opened in a disarticulation, the form of the resulting stump, and the position of the cicatrix. The comparative merits of these methods and their various modifications will be discussed in connection with the different operations. They may be essentially modified by accidental circumstances, and by the necessity which sometimes arises, as in cases of injury, of fashioning the flap from such tissues as are available.

CIRCULAR METHOD.

1ST TIME. The cutaneous incision should be made at a distance below the point where the bone is to be divided equal to two-thirds of the diameter of the limb at that point. While an assistant draws the skin firmly and evenly toward the root of the limb, the operator passes his hand below and beyond it, and places the heel of the knife upon its upper surface, its point directed toward his own shoulder. He then sweeps the knife entirely around the limb, dividing the skin and subcutaneous cellular tissue, down to the enveloping fascia, and terminating the incision at the point where it began.

2D TIME. *a.* The skin and cellular tissue are retracted and the muscles divided in succession, the deeper ones at higher levels, so that the surface of section forms a cone, the apex of which is directed upward. The muscles whose origins are most distant must be cut long to allow for their greater retraction.

b. (*Alanson's method.*) The point of the knife is passed obliquely down from the edge of the skin to the bone at the point where it is to be divided, and carried around the limb, always at the same angle with the bone, so as to form the muscular cone by a single incision.

c. (*Cutaneous sleeve.*) The skin and cellular tissue are separated cleanly from the deep fascia and turned back over the limb, the raw surface outward. The sleeve thus formed is lengthened by drawing it up and dividing its attachments to the fascia, care being taken to include all the subcutaneous cellular tissue in it, until the dissection has nearly reached the height at which the bone is to be divided. The fascia and muscles are then cut through to the bone transversely with a single sweep of the knife, held as for making the cutaneous incision.

3D TIME. *Division of the Bone.* The soft parts being drawn up and protected by a piece of leather or a cotton band four inches wide and two feet long, split for half its length so as to pass on each side of the bone (called the *retractor*), and the periosteum having been divided circularly with the knife along or a little below the line to be traversed by the saw, the operator places the heel of the saw upon the bone, steadies its edge with the thumb-nail of his left hand, and draws it slowly toward himself, cutting a deep groove in the bone; he then completes the division with a few rapid strokes of the instrument, while the limb is firmly held by two assistants, so as to prevent binding of the saw or splintering of the bone. The periosteum may first be dissected up for half an inch, so as to form a sort of curtain to overhang the end of the bone.

If there are two bones the retractor should be split into three instead of two parts, and the central one passed be-

tween the bones. The saw should be first applied to the larger bone, and, after cutting a deep groove in it, should be inclined backward or forward, so as entirely to divide the second before completing the division of the first.

OVAL METHOD.

A scalpel is used instead of the amputating knife; the incision is commenced at the level at which the bone is to be divided, is carried downward on one side, across the back of the limb, and upward on the opposite side to the point at which it began. The details will be given in connection with certain disarticulations to which this method is especially applicable.

FLAP METHOD.

The flaps may be single or double, antero posterior, bilateral, long rectangular (Teale), or skin flaps with circular division of the muscles (modified flap operation). They may be made by transfixion or from without inward. In making a flap by transfixion it is well first to mark its outline by an incision through the skin and cellular tissue with a scalpel, as otherwise there is danger of making its point too narrow or its edges jagged. The point of the amputating knife is then entered at the nearest angle of the incision and passed through to the other, hugging the bone on its way, and the cut made steadily downward and outward, with sawing movements of the knife. It is then re-entered and brought out at the same points, but passing on the opposite side of the bone, and the second flap cut in the same manner as the first. The fibres on each side of the bone which have escaped are then divided, the retractor applied, and the bone sawed through as above.

In cutting a flap from without inward the scalpel must be entered at one of the angles of the base of the proposed flap, carried along a curved line down to the apex of the flap, and thence up to the other angle of the base. The presence of a tumor, or injury to, or disease of, the soft parts may render it necessary to modify the shape of the

flap or vary the obliquity of the incision, so as not to include any unfit tissue in the former.

Skin Flaps and Circular Division of the Muscles. In this operation the flaps include only the skin and subcutaneous cellular tissue dissected off from the deep fascia; the latter and the muscles are divided transversely by a sweep of the knife at the base of the flap, the retractor applied, and the bone cleaned and divided a little higher up.

Long Anterior Flap. An anterior flap, its length somewhat greater than the antero-posterior diameter of the limb at its base, is cut by transfixion, or from without inward; the posterior muscles and segment of skin are cut straight across a little below the point of division of the bone, and the anterior flap brought down to cover their cut surface. This method furnishes a good covering for the bone, free drainage for the secretions of the wound, and a well-placed cicatrix.

In every amputation it is well to dissect out the main nerve trunks, and cut them off high up between the muscles, so that their ends may not become imbedded in the cicatrix or involved in the supuration.

The choice of one or another method will often be determined by the anatomical and pathological circumstances of the case. When any one may be used, the preference is usually given now to the skin flap with circular division of the muscles.

Teale's Method. In the method to which Mr Teale's name has been given a very long rectangular anterior flap, comprising half the circumference of the limb and all the tissues down to the bone, is made and doubled back upon itself, thus furnishing a thick pad for the bone and a posterior cicatrix. The method of operating is as follows: (Fig. 46, B) A rectangular anterior flap (posterior in the forearm), equal in length and breadth to half the circumference of the limb at the base of the flap, is marked out by one transverse and two parallel longitudinal incisions, the latter involving only the skin, the former being carried down to the bone. The longitudinal incisions should

be so placed that the principal vessels and nerves will not be included in this flap, but in the posterior one, which is also bounded by a transverse incision carried down to the bone, and is only one-fourth as long as the anterior one. The two flaps are now in turn dissected up close to the bone, and the saw applied at their base. After the vessels have been secured the long flap is doubled back upon itself, and its square end fastened to that of the other with sutures; two or three points of suture are also required to keep the sides of the short flap and of the reversed portion of the long flap in contact with the rest of the latter.

It is found that by retraction of the short posterior flap the cicatrix is drawn up behind and out of the way of the bone, and that a soft mass without any large vessels or nerves is the result of the partial atrophy of the long flap, and forms an excellent, non-sensitive stump. The principal objection to this method, and one which greatly restricts its applicability, is the great length of the anterior flap, which can be obtained in many cases only by dividing the bone at a much higher point than would otherwise be necessary.

AMPUTATION OF THE FINGERS.

Phalanges. When the injury or disease is limited to one or two fingers, and it is of such a nature that the member will be useless, if preserved, the afflicted phalanx or finger should be removed without hesitation; but usually it is desirable to save as much as possible of the parts, and therefore whenever a choice can be made amputation in continuity is to be preferred to disarticulation higher up. The incisions should be so arranged that the cicatrix will not lie upon the palmar surface, and for this, as well as for anatomical reasons, the principal flap should be taken from the flexor aspect. No special directions are required for amputation or disarticulation of the middle and distal phalanges. For amputation through the shaft the incision may be circular with a longitudinal addition one-third of an inch long on each side, or the single anterior flap by transfixion may be used. In disarticulation it is best to enter the joint from the dorsal side with a narrow-bladed knife, and cut

the anterior flap by carrying the knife through the joint and then forward, hugging the bone.

It must be remembered that the folds on the palmar surface of a finger do not correspond exactly to the joints; the first being half an inch beyond, the middle one a line above, and the distal one a quarter of an inch above the articular surfaces, and also that the prominence of a knuckle when the finger is flexed is formed entirely by the head of the proximal and not by the base of the distal phalanx. When the tissues have not become thickened and infiltrated the articular depressions can also be felt upon the sides.

Amputation through the Metacarpophalangeal Articulation. The articular depression can be found very easily by passing the thumb and forefinger along the sides of the finger, especially if the latter be at the same time drawn forcibly away from its metacarpal bone.

The incision should be commenced over the dorsum of the metacarpal bone a quarter of an inch above the articulation, carried through the interdigital web, and then back on the palmar face to a point a quarter of an inch above the flexor fold (Fig. 32, C'); a similar incision, beginning and ending at the same points, is made on the other side of the finger, the flaps dissected back, the lateral ligaments divided while the finger is drawn first to one side and then to the other so as to facilitate access to them and at the same time make them tense, and then the tendons and the remainder of the capsule divided as the finger is withdrawn.

Or an incision may be made only on the side corresponding to the right hand of the operator, the flap dissected back to the joint, the lateral ligament divided, the knife carried transversely through the joint, dividing the tendons and the other lateral ligament, and the other flap cut from within outward, care being taken to make it sufficiently broad.

The head of the metacarpal bone should be removed only in cases where it is more desirable to diminish the deformity than to preserve the strength of the hand.

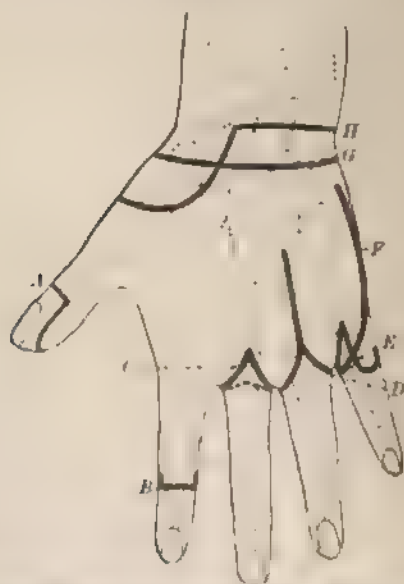
An artery on each side will have to be secured, and the wound closed with sutures.

The incisions may be advantageously modified for the index and little fingers by making a full lateral flap on the free side and carrying the incision transversely across the palmar surface to the angle of the web, and thence obliquely back to the knuckle (Fig. 32, *E*).

AMPUTATION OF THE METACARPAL BONES.

As the articulations of the first and fifth metacarpal bones with the carpus do not communicate with the other and

FIG. 32.



A Disarticulation of the phalanx anterior tip. *B* Amputation in continuity, circular. *C* Metacarpophalangeal disarticulation. *D* Amputation of a metacarpal bone in continuity. *E* Disarticulation of little finger. *F* Disarticulation of fifth metatarsal. *G* Amputation of wrist circular. *H* Amputation of wrist (DEBOUT).

larger synovial sacs, these bones may be entirely removed without much danger of setting up inflammation within the

wrist-joint, but in the case of the other three amputation in continuity is preferable to disarticulation. The relations of the synovial sheaths of the flexor tendons are also of importance in the operation. There is no communication between the main sheath in the palm of the hand and the sheaths of the second, third, and fourth fingers, and consequently, if the tendons are divided as low down as the metacarpo-phalangeal articulation, inflammation of the main sheath with all its disastrous consequences will probably be avoided.

The incisions are the same as for amputation through the metacarpo-phalangeal articulation, with a prolongation upward as far as may be necessary over the back of the bone (Fig. 32, *D*). After its posterior and lateral surfaces have been bared, the bone is cut through with pliers at the point determined on, or disarticulated from the carpus, and the distal fragment is raised from its bed, and, beginning at the upper end, its under surface carefully separated from the soft parts.

In disarticulation of the fifth metacarpal, the incision should be made along the inner border of the hand, and carried down to the bone between the skin and the abductor minimi digiti rather than through the fibres of the latter (Fig. 32, *F*). This gives easier access to the palmar ligaments uniting the bone to the carpus. The lower end of the incision should form a loop with its centre in the interdigital web, and its point on the line of the knuckle.

AMPUTATION AT THE WRIST.

(*Radio-carpal Disarticulation.*)

Circular Method (Fig. 32, *G*). While an assistant retracts the skin upon the forearm, the operator sweeps his knife transversely around the wrist, half an inch below the point of the styloid process of the radius. The skin and as much cellular tissue as possible are divided and dissected back as far as the joint, which is then opened by entering the point of the knife just below the styloid process of the

radius, and the disarticulation completed while the hand is drawn firmly away from the arm.

Antero-posterior Flaps. The absence of muscular fibres at the wrist deprives this method of most of the advantages which it offers at other points, and the projection on the palmar surface of the trapezium and pisiform bones renders its execution difficult, and makes it practically identical with the circular method supplemented by lateral incisions. It should be reserved for cases in which the skin is so infiltrated that it cannot be readily dissected back.

An incision curved downward is carried across the back of the wrist from one styloid process to the other, the flap dissected up, the hand flexed forcibly, the extensor tendons divided, the joint opened beneath them, and the palmar flap, which should extend as far down as the base of the metacarpal bones, cut from within outward.

Or the palmar flap may be made from without inward, or by transfixion, before the joint has been opened.

External Lateral Flap. Dubrueil¹ (Fig. 32, H) The hand is pronated, and the operator makes a curved incision, which, beginning on the dorsal aspect a quarter of an inch below the radio-carpal articular line, at the junction of the outer and middle thirds, passes downward, crosses the outer side of the first metacarpal bone at its centre, and returns to a point on the palmar surface opposite that at which it began. Its two ends are then joined by a transverse incision passing around the inner side below the end of the ulna. The external flap is dissected up, the joint opened at the radial side, and the disarticulation completed.

AMPUTATION OF THE FOREARM.

The forearm may be divided, with reference to surgical considerations, into upper, middle, and lower thirds. Its shape is cylindrical near the elbow, and gradually flattens and narrows toward the wrist. The lower half of the radius

and the whole length of the ulna are subcutaneous. The coverings of the lower third are composed almost exclusively of skin and tendons, while thick muscular masses cover the upper two thirds, especially on the anterior aspect. The absence of suitable coverings in the lower third, and the presence there of so many synovial sheaths, the inflammation of which may give rise to dangerous complications, have led some surgeons (Baron Larrey, Sedillot) to advise strongly against amputating at this part. On the other hand, it is important for the subsequent usefulness of the limb that the movements of pronation and supination should be preserved, and this can only be done by dividing the bones below the insertion of the pronator radii teres, which is just above the middle of the radius; if the division has to be made above this point the rule is to save as much as possible, especially the insertion of the biceps.

For the reasons stated, the only method applicable to the lower third is the circular one, and if the conicity of the limb or the infiltration of the parts should otherwise render it impossible to carry the dissection of the cutaneous sleeve to a sufficient height, the circular incision must be supplemented by a short longitudinal one in front. The division of the tendons should be on the same level with that of the bone, and is best accomplished by passing the knife under them, and cutting directly outward.

In the upper two-thirds the difficulty of dissecting a cutaneous sleeve is likely to be still greater, and has led to general rejection of the circular method. On the other hand, lateral flaps are impossible, and the bones have a tendency to project at the angles if antero-posterior flaps are made. Many methods have been proposed to obviate this difficulty, in all of which the essential point is the same, namely, to divide the bones at least half an inch above the angles of the incision through the skin. Sedillot made short thin musculo-cutaneous flaps, and divided the deep muscles obliquely according to Alanson's method (p. 69); Richet makes short flaps, including all the soft parts, dissects them up circularly from the bones for about three quarters of an inch, and divides the latter at the height thus reached. Tillaux recommends short skin flaps to be dissected up for three-quarters of an inch above their base, and then short

muscular flaps to be made parallel to the former by transfixion at the higher level. When there is sufficient available material on the back of the arm for a long flap, Teale's method gives good results.

High up in the upper third, where the position of the bones is more central, and thick muscular masses lie upon the sides, the short flaps should be lateral.

AMPUTATION AT THE ELBOW-JOINT.

The guides to the articulation are the epitrochlea on the inner, the epicondyle and the head of the radius on the outer side. The smooth rounded prominence formed by the latter can be readily felt about half an inch below the epicondyle; and the interarticular line starting from it passes at first transversely and then downward and inward toward a point an inch below the epitrochlea, and forms an angle, opening inward, with the transverse diameter of the lower end of the humerus. It is therefore unnecessary to expose the epicondyle and epitrochlea in disarticulating; and these relative positions should be constantly kept in mind during the operation. The skin is freely movable in front, but is adherent to the ulna behind.

The methods in common use are the interior flap, lateral flap, and circular.

Anterior Flap. The joint may be opened (a) from behind, or (b) from in front

a. *From behind* (Sédlillot.) The forearm is flexed, and an incision, slightly convex downward and interesting only the posterior third of the circumference, is made one and a half inches below the tuberosities of the humerus. The skin is dissected up to the tip of the olecranon, the tendon of the triceps divided, the point of the knife passed into the joint and carried first to one side and then to the other, cutting the posterior and lateral ligaments. A longitudinal incision two and a half inches long is then carried downward from the outer end of the first, the forearm, still flexed, is pressed backward and inward, and the disarticulation readily completed by passing the knife through the joint,

and cutting down and out on the anterior aspect while the skin is forcibly retracted.

b. From in front. (Fig. 33, *A*.) The flap may be made by transfixion, or from without inward; in either case it should be at least three inches long, and its base should be parallel to and three-quarters of an inch below a line drawn through the epicondyle and the epitrochlea. Some surgeons prefer to make the line of the base oblique downward and outward, because the muscles on the outer side have their origins at higher points on the humerus, and retract more than those on the inner side. The posterior incision should be slightly convex downward, and should begin and end at the same points as the anterior one.

The head of the radius is then sought for, and the joint opened by entering the knife between it and the humerus and completely dividing the external lateral ligament. The capsule is divided in front by passing the point of the knife along the edge of the ulna over the coronoid process to the internal lateral ligament, which should be cut as high as possible. The olecranon is disengaged from the humerus by drawing it down forcibly, the attachment of the triceps divided, the knife passed behind the bone, and the remaining tissues divided from within outward.

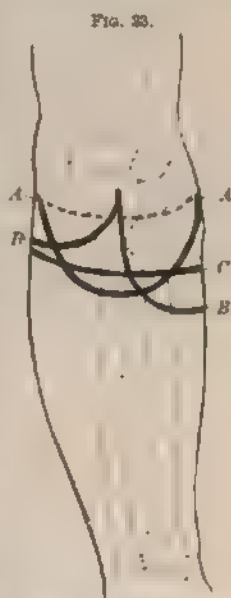


FIG. 33.

Amputation at the elbow-joint. *A* Anterior flap. *B* External flap. *C* Circular method.

Lateral flap. (Fig. 33, *B*.) An external flap four or five inches long is made by transfixion from a point in the median line in front, a finger's breadth below the bend of the elbow; or from without inward by an incision beginning at the same point and ending half an inch higher on

the posterior face of the ulna. A second incision is made transversely across the inner side of the arm about an inch below the upper end of the first. The radio-humeral joint is opened, and the disarticulation completed as before.

Instead of a single external flap, two lateral flaps may be made, but the external should be half an inch longer than the internal one.

Circular. (Fig. 33, C.) An incision, transverse or a little lower on the outer than on the inner side, is made about the limb three and a half inches below the epitrochlea, and carried down to the enveloping fascia; the cutaneous sleeve is dissected up for about an inch, and the muscles divided transversely at its base. They are then retracted forcibly by an assistant so as to form a cone with its apex directed downward, and the deep muscles of the anterior aspect are again divided transversely on a level with the radio-humeral articulation, the external lateral ligament being included in the incision and the joint thereby opened. The disarticulation is completed as before described.

AMPUTATION OF THE ARM.

This may be performed at any point below the attachments of the muscles of the axilla. Disarticulation at the shoulder is preferable to amputation in continuity above these attachments. As the bone is centrally placed and well covered on all sides, any one of the usual methods of amputation may be employed. As a general rule the biceps should be divided at a lower level than the other muscles because it is not adherent to the humerus, and therefore retracts more than the others. The circular incision should be half an inch lower on the inner than on the outer side. In muscular subjects flaps should be cut rather thin, and, when possible, it is better that the main artery should be in the posterior flap.

AMPUTATION AT THE SHOULDER-JOINT.

General Considerations. The exposed position and great accessibility of the head of the humerus have led to the

suggestion of many operative methods, most of which can be performed with much ease and regularity upon the cadaver, and yield good results in actual practice, amputation at the shoulder-joint being, perhaps, the most successful of the major amputations. But as the operation is usually rendered necessary by malignant disease or compound fracture of the humerus, under circumstances which make it very difficult, if not impossible, to follow regular methods, it is more important to be familiar with the anatomy of the parts and the general principles governing all the methods than with the details of the different ones.

The size of the axillary artery and the difficulty of efficiently compressing the subclavian make the management of the artery an element of prime importance in this operation. The joint should be approached from the outer side, and the artery divided from within outward after disarticulation, an assistant passing his thumb into the wound above the knife and compressing the vessel before it has been cut. Or the artery may be exposed during the operation and tied before it is cut.

Pressure upon the subclavian may be made by the thumb of an assistant standing behind the patient, or by the well-padded handle of a door key or tourniquet, or a rubber tube or cord tightly encircling the axilla, scapula, and clavicle. To prevent slipping of the cord a long mattress-needle is sometimes introduced near the tip of the coracoid process, carried through the capsule of the joint, grazing the head of the humerus, and made to emerge posteriorly near the axillary border of the scapula. The cord is then applied circularly on the proximal side of the skewer.

Wyeth¹ applies an Esmarch rubber bandage from the fingers to the axilla, and then passes a skewer through the anterior axillary fold, piercing the tendon of the pectoralis major from above down, and another skewer from before backward just below the acromion process through the fibres of the deltoid. After placing the rubber cord on the proximal side of the skewers the Esmarch bandage is removed.

The subsequent retraction of the pectoralis major and latissimus dorsi leads to gaping of the wound and the for-

¹ Journ. Am. Med. Assoc., February 7, 1901.

mation of a broad, unsightly, triangular cicatrix. This must be met by retaining all the skin for the first two or three inches in the flaps, not allowing the incisions to diverge from one another until the end of the flap is nearly reached. This precaution also insures ample covering for the projecting acromion. The outer flap should comprise the entire thickness of the deltoid so that the gap left by the head of the humerus may be properly filled, and it should be dissected up close to the bone so as to avoid injury to the trunk of the posterior circumflex artery.

Instead of attempting to separate the capsule at its attachment to the upper edge of the glenoid cavity by passing the point of the knife under the acromion, it is better to divide it near its centre by drawing the edge of the knife across the upper surface of the head of the humerus; and in all incisions beginning between the acromion and coracoid process the point of the knife should be passed directly down to the humerus so as to divide the strong fibrous arch connecting the two processes.

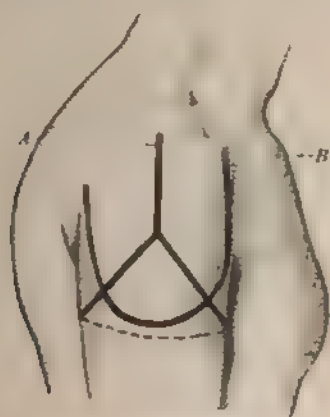
Oval Method (Baron Larrey). (Fig. 34, A.) A longitudinal incision involving all the tissues down to the bone is made on the outer aspect of the shoulder from the edge of the acromion to a point one inch below the neck of the humerus, and an oval one interesting the skin only is then carried from its lower end around the arm, crossing its inner side about an inch below the border of the axilla. The flaps thus marked out are dissected up, the anterior one carefully, until the tendon of the pectoralis major is exposed, and divided close to its insertion, the posterior one more boldly, but close to the bone, so as to avoid injury to the trunk of the circumflex artery. The capsule is freely divided across the head of the humerus, the arm rotated inward and then outward so as to facilitate the division of the tendons of the articular muscles, which is best accomplished by cutting directly upon the tuberosities, the humerus thus liberated is thrown outward by adducting the elbow, the knife is passed behind it and carried down and out through the cutaneous incision on the inner side, while an assistant compresses the artery in the wound.

The resulting wound is comparatively small, allows free

drainage at its lower angle, is likely to unite by first intention in its upper half, and usually leaves a linear cicatrix.

After cutting through the tendon of the pectoralis major, Verneuil isolates the biceps and coraco-brachialis with his fingers, divides them, seeks for the artery, and ties it rather high up before continuing the operation.

FIG. 34.



Disarticulation at the shoulder

A Oval method B Method by double flaps.

It is sometimes not easy to reach and divide the broad tendon of the subscapularis; and when the humerus is broken it is, of course, impossible to use it as a lever to force the head of the bone out of the socket, and this part of the operation may thereby be rendered somewhat difficult. These and the hemorrhage from the branches of the posterior circumflex are the principal objections to this method, which has, nevertheless, yielded excellent results.

The articulation is uncovered more freely by any of the double flap methods in which an external flap is fashioned out of the deltoid muscle. Of these the Lastranc method may be taken as the type, premising only that while the opening of the articulation by transfixion is very easy of execution upon the cadaver, it is sometimes impossible upon the living subject, and inapplicable to cases of malignant

disease of the humerus. Under such circumstances the flaps must be made by dissection from without inward.

Double Flap Method (Lisfranc). (Fig. 34, B.) Right shoulder. While the arm is abducted the surgeon enters the point of a two-edged amputating knife at the outer side of the coracoid process, carries it across the outer aspect of the head of the humerus, and brings it out a little below the posterior border of the acromion. He then raises the fibres of the deltoid with his left hand, works the knife downward around the head of the bone, and cuts a broad flap about five inches long. In this manoeuvre the joint should be opened at its upper part, the tendons of the supra-spinatus and long head of the biceps entirely divided, and those of the subscapularis and infra-spinatus partly divided. The arm is then adducted, the knife passed through the joint to the inner side, and a long inner flap cut from within outward.

Left shoulder. The knife is passed in the opposite direction, that is, from below the acromion behind to the coracoid process in front, and the operation completed as on the right side.

Spence's Method. Prof. Spence has introduced a method, for which he claims the following advantages: 1st. The better form of the stump. 2d. The division of the posterior circumflex artery only in its terminal branches in front. 3d. The great ease with which disarticulation can be accomplished. Another advantage is that an operation for excision of the head of the humerus can be easily transformed into a disarticulation by its means, should that be found necessary.

He describes the operation as follows (Fig. 35)? "The arm being slightly abducted, and the humerus rotated outward, I cut down upon the head of the humerus immediately external to the coracoid process, and carry the incision down through the clavicular fibres of the deltoid and pectoralis major muscles, till I reach the humeral attachment of the latter muscle, which I divide. I then, with a

gentle curve, carry my incision across and fairly through the lower fibres of the deltoid toward, but through, the posterior border of the axilla. Unless the textures be much torn, I next mark out the line of the lower part of the inner section by carrying an incision through the skin and fat only, from the point where my straight incision terminated, across the inside of the arm to meet the incision at the outer part. If the fibres of the deltoid have been thoroughly divided, the flap, together with the posterior circumflex artery, can be easily separated by the point of the finger from the bone and joint, and drawn upward and backward so as to expose the head and tuberosities without further use of the knife. The tendinous insertions of the capsular muscles, the long head of the biceps, and the capsule are next divided by cutting directly on the bone. Disarticulation is then accomplished, and the limb removed by dividing the remaining soft parts on the axillary aspect.

"In cases where the limb is very muscular I dissect the skin and fat from the deltoid at the lower part, and then divide the muscular fibres higher up by a second incision, so as to avoid redundancy of muscular tissue."

FIG. 23.



Disarticulation at
the shoulder.
Spencer's method

AMPUTATION OF THE ARM, SCAPULA, AND PART OR ALL OF THE CLAVICLE.

Make an incision along the ureter two-thirds of the front of the clavicle; carry the incision through the periosteum. Divide the periosteum transversely at the inner angle of the wound and strip it as far as possible from the middle third of the bone. Then pass a periosteal elevator or blunt hook beneath the clavicle at the inner angle of the wound to protect the underlying parts, and saw through the bone

at this point. Raise the sawn end of the outer fragment, strip off the periosteum from its deeper surface, and saw it through again at about the junction of the outer and middle thirds. Through the gap thus made the great vessels are exposed and divided between separate double ligatures for each, close to the first rib.

FIG. 26



Amputation of the arm, scapula, and part or all of the clavicle. (The dotted lines represent the part of the incision which lies on the posterior aspect of the body.) (Treves.)

A second incision is made from the centre of the first downward and outward, along the groove between the pectoral and deltoid muscles, to the junction of the anterior axillary fold with the arm. Thence across the inner surface of the arm to the junction of the posterior axillary fold with the arm, dividing at this point the tendons of the teres major and latissimus dorsi; thence the incision is carried downward and inward between the teres major and latissimus dorsi to the inferior angle of the scapula.

The skin and subcutaneous tissue over the anterior fold of the axilla is raised, and the pectoralis major cut where it begins to become tendinous.

The pectoralis minor is severed close to the coracoid process, and after division of the cords of the brachial plexus at the level where the great vessels were cut, only the muscles attached to the trunk and scapula retain the limb.

The patient is then turned toward the opposite side. Another incision, through the skin and subcutaneous tissue, is carried from the outer end of the first clavicular incision at the acromio-clavicular joint, across the spine of the scapula to terminate in the second incision at the inferior angle of the scapula. The skin and subcutaneous tissue on the inner side of the incision are raised sufficiently to permit division of the clavicular and scapular attachments of the trapezius.

Then, starting at the outer end of the superior border of the scapula, the omohyoid, levator anguli scapulae, rhomboideus minor and major, and the serratus magnus are divided in this order close to the bone, and the limb detached.

The early ligation of the subclavian vessels prevents any great loss of blood. The sutured wound forms an oblique line running from above downward, outward, and backward.

AMPUTATION OF THE TOES.

The different phalanges of the toes may be removed by the same methods, and at the same points, as those of the fingers, but experience has shown that, except for the great toe, it is better to disarticulate at the metatarso-phalangeal joint, the preservation of a portion of a toe being a source of discomfort rather than an advantage. In the case of the great toe it is desirable to save as much as possible, and amputation in continuity is to be preferred to disarticulation. In all operations upon the foot the incisions should be so arranged that the cicatrices will not occupy the plantar surface. It must be remembered that the web between the toes lies far below the metatarso-phalangeal joint. (Fig. 37.)

The incision should be commenced on the dorsal surface a little above the joint, carried directly down the bone for about an inch, and then, diverging abruptly, into the web, straight across

FIG. 37

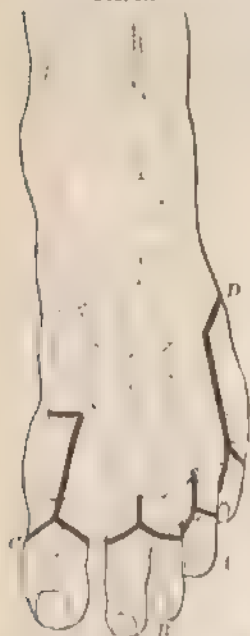


Relation of the web and metatarso-phalangeal joint

in the digito-plantar fold, and back on the other side to the point of divergence (Fig. 38, *A*). If the strong flexor tendons have been completely divided it will then be found easy to disarticulate by entering the knife at the side of the joint. This oval incision is better than the two lateral semilunar flaps, because its cicatrix does not extend into the sole of the foot.

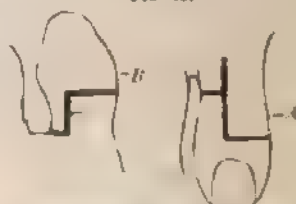
The distal phalanx of the great toe may be removed according to the methods described for the corresponding part of the thumb and fingers (p. 72).

FIG. 38.



Amputation of the toes and metatarsal bones

FIG. 39.



Amputation of the great toe

*Disarticulation of the great toe at the metatarso-phalangeal joint may be done according to the method just described for the other toes, or with a large internal flap. In the latter case an incision (Fig. 39, *A*) is begun on the outer side of the extensor tendon just below the joint, and carried straight down to the head of the first phalanx. From its lower end a transverse incision is carried around the inner side of the toe to the outer edge of the flexor tendon, and, the toe being then forcibly extended, a plantar excision*

*is carried from the end of the transverse incision (Fig. 39, *B*), along the outer side of the flexor tendon to the digito-plantar fold, and thence transversely around the*

outer side of the toe to rejoin the first incision near its centre.

The internal flap is then dissected from below upward, the extensor tendon divided high up, the lateral ligaments divided, the knife passed through the joint, and the remaining soft parts cut from within outward.

The same incisions made somewhat lower down may be used for amputation in continuity, but usually the shape and position of the flaps will be determined by the nature and extent of the injury which makes the operation necessary.

Amputation of two adjoining Toes. The dorsal incision should begin in the intermetatarsal space just above the level of the joint (Fig. 38, B), extend down to the beginning of the web, diverge obliquely to the adjoining web, cross the plantar surface in the digito-plantar fold of both toes, and return through the other adjoining web to the point of divergence. Each toe is then removed separately after division of its tendons and lateral ligaments.

AMPUTATION OF A METATARSAL BONE.

Amputation in continuity is much to be preferred to disarticulation on account of the extent of some of the synovial sacs, the attachments of certain muscles, and the importance of some of the bones in preserving the relations of the others. The synovial sac which forms part of the articulation between the first cuneiform and first metatarsal bones is isolated from the others, but the attachment of the peroneus longus to the base of the latter bone renders its preservation especially important. There is also a separate synovial sac for the articulation between the cuboid and the fourth and fifth metatarsals. The base of the fifth metatarsal is easily recognized by the prominence which it forms on the outer side of the foot; that of the first metatarsal is three-fourths of an inch anterior to the other, and is the first prominence encountered by the finger when it is passed from before backward along the inner side of the bone.

The incision begins on the dorsal aspect at, or a little below, the point at which the bone is to be divided, is carried

down well below the metatarso-phalangeal joint (Fig. 38, C), diverges into the web, crosses the plantar surface in the digito-plantar fold, and returns through the other web to the point of divergence. A short transverse incision is made through the skin at its upper end to facilitate division of the bone, which is then effected with cutting pliers or a chain saw after the soft parts have been separated on both sides. The toe is then pressed backward, the cut end of the bone raised, the knife passed behind it, and the operation completed by cutting from within outward. The first and fifth metacarpal bones should be cut obliquely so as to diminish the prominence of the stump.

For *disarticulation of the first or fifth metatarsal bones* the only modification needed is to begin the incision at a correspondingly higher point—at or a little below the tarso-metatarsal joint (Fig. 38, D). After the flaps have been dissected up, the joint is opened by dividing the dorsal and interosseous ligaments, and the bone raised and separated from the remaining soft parts.

DISARTICULATION OF ALL THE METATARSAL BONES.
(TARSO-METATARSAL DISARTICULATION; LISFRANC'S
OR HEY'S AMPUTATION.)

The position and general direction of the tarso-metatarsal articulations, as well as the peculiarity presented by the base of the second metatarsal bone, are sufficiently well shown in Fig. 40 to render a detailed description unnecessary. The guides to the articulation are the projecting bases of the first and fifth metatarsal bones.

The skin being retracted by an assistant, the surgeon makes with a scalpel a curved incision across the dorsum of the foot from the base of the fifth to the base of the first metatarsal bone. (For the left foot the direction of this incision must be reversed.) The incision should involve the skin only, its centre should lie half an inch or more below the centre of the line of the articulations, and it should begin and end upon the sides of the foot at their junction with the sole. (Fig. 40.)

A plantar flap should then be marked out by a curved incision beginning and ending at the same points as the first and crossing the sole near the origin of the toes. The dorsal skin flap is then dissected back to the line of the articulation, the tendons and muscular fibres of the short extensor divided, the joints between the fifth, fourth, and third metatarsals, and the corresponding bones of the tarsus opened successively from the outer side, and that between the first metatarsal and first cuneiform from the inner side. With the point of the knife directed transversely across the dorsal aspect of the base of the second metatarsal, the joint between that bone and the second cuneiform is sought from below upward, and after it has been found and opened the interosseous ligaments uniting the second to the first and third metatarsals are divided by thrusting the point of the knife well down between them, the flat of its blade being held parallel to the long axis of the foot, and the toes being forcibly depressed.

After the bone has been thus disengaged, the knife is passed through the articulation, and the plantar flap cut from within outward.

Modifications. The plantar flap may be cut (1) from without inward, or (2) by transfixion, before the articulations have been opened. Instead of disarticulating it, the base of the second metatarsal may be cut off with pliers or a saw and left in place. Hey sawed off the projecting part of the first cuneiform after disarticulating, but this weakens the attachment of the tibialis anticus, a disadvantage which is not offset by the improvement in the outline.

FIG. 40



A Lisfranc's amputation.
B Chopart's amputation.

MEDIO-TARSAL OR CHOPART'S AMPUTATION.

This name is given to the operation of disarticulation through the joints formed by the astragalus and calcaneum behind, the scaphoid and cuboid in front. The guides to the joint are the tubercle of the scaphoid on the inner side of the foot, the head of the astragalus on the dorsum, and the anterior end of the calcaneum on the outer border. The first named is one-eighth of an inch in front of the articulation, and is the first bony prominence found on drawing the finger from the inner malleolus forward along the side of the foot; the sharp edge of the second can be readily felt when the anterior portion of the foot is forcibly depressed; the latter can usually be made out by adducting the toes and inverting the sole, nearly midway between the tip of the external malleolus and the base of the fifth metatarsal bone, or nearer the latter. When the foot is at right angles with the leg, the anterior articular surfaces of the astragalus and calcaneum are in the same plane, one crossing the foot transversely at the points indicated.

FIG. 41.



Outer side. A Chopart's amputation B Syme's amputation C Subastragaloid amputation D Line of section of the bones in Syme's amputation

Operation. (Figs. 40, 41, 42.) The surgeon places the thumb and forefinger of his left hand upon the tubercle of

the scaphoid and the lower and outer border of the cuboid, with the palm against the sole, and makes a curved incision from one to the other, passing an inch anterior to the head of the astragalus, and terminating on each side just below the level of the joint. The plantar flap is next marked out by an incision beginning and ending at the same points as the first, and crossing the sole of the foot four or five finger-breadths nearer the toes. The dorsal flap is next dissected up, the joint entered at either of the points mentioned as guides (preferably between the astragalus and scaphoid on the inner side, after dividing the tendons of the tibiales), opened widely by dividing the dorsal and interosseous ligaments and depressing the toes, and the plantar flap cut from within outward.

Syme preferred to make the plantar flap by transfixion before disarticulating.

The anterior tendons should be stitched to the deep tissues, and the dressing should keep the foot in extreme dorsal flexion at the ankle in order that these tendons may so unite with the stump that their muscles will prevent the heel from being raised by the unopposed action of the muscles of the calf.

Tripier's amputation is practically a modification of *Chopart's*. Its purpose is to afford a broad and level basis of support by sawing the os calcis from its upper posterior to its anterior inferior angle, and so prevent any raising of the heel, an objectionable feature in *Chopart's* operation. The incision begins at the outer edge of the tendo Achillis on a line with the tip of the external malleolus, passes forward about an inch below the latter to a point a finger's-breadth behind the base of the fifth metatarsal, thence across the dorsum of the foot with a gentle curve to the extensor proprius hallucis tendon over the astragalo-scaphoid joint; thence forward on the superior surface of the scaphoid and internal cuneiform to near the base of the first metatarsal. From this point it curves around the inner border of the foot and across the sole to its outer edge at the base of the fifth metatarsal, and thence upward and backward to join the dorsal incision. The anterior portion of the foot is removed through the

astragalo scaphoid and calcaneo-cuboid joints, the soft parts elevated from the inferior and internal surfaces of the os calcis, and the latter sawn through horizontally just below the sustentaculum tali. The saw-cut is oblique to the long axis of the calcaneum, which is normally elevated toward the front.

SUB-ASTRAGALOID AMPUTATION.

(Figs. 41, C, and 42, C.) The guides to this operation are the tip of the external malleolus and the head of the astragalus. The joint must be entered from in front on the

FIG. 42



Inner side A Chopart's amputation B Syme's amputation
C Subastragaloid amputation

fibular side, and the strong interosseous ligament which forms the key to the articulation must be divided step by step from before backward and inward. The posterior tibial vessels lie behind the inner malleolus, and must be carefully avoided.

Beginning at the outer side of the heel, nearly an inch below the tip of the external malleolus, an incision, extending through to the bone, is carried straight forward to the base of the fifth metatarsal bone; thence, curving forward, across the dorsum of the foot to the base of the first metatarsal; thence obliquely backward and outward across the

sole of the foot and around its outer border, rejoining the first and horizontal part of the incision at the calcaneo-cuboid articulation. The soft parts must be separated from the outer surface of the calcaneum and cuboid with division of the peroneal tendons, the dorsal flap dissected back to the head of the astragalus, and, on the inner side, beyond the tubercle of the scaphoid, thus dividing the tendon of the tibialis anticus and the anterior portion of the internal lateral ligament. The interosseous ligament can then be easily reached by depressing the toes, passing the knife between the astragalus and scaphoid, and cutting backward and inward along the under surface of the former. The soft parts on the inner side are then separated from the calcaneum, injury to the vessels being avoided by keeping close to the bone, between it and the tendon of the flexor communis, the foot depressed, and the tendo Achillis divided. This last is a very difficult part of the operation, and great care must be taken to keep the edge of the knife close to the bone, so as not to cut through the skin.

The posterior tibial nerve should be dissected out and cut off as high up as possible, so that it shall not be pressed upon the stump.

Farabeuf has slightly modified this, as follows:

The incision is begun at the outer margin of the tendo Achillis, close to the upper border of the os calcis, and carried horizontally forward along the outer side of the latter bone, passing about one inch below the external malleolus. At the base of the fifth metatarsal it turns over the dorsum of the foot to the base of the first metatarsal, thence across the sole to its outer margin opposite the base of the fifth metatarsal. From this point it passes backward along the outer edge of the plantar surface of the foot to the posterior external tubercle of the os calcis, whence it curves upward to the starting-point at the upper and back part of the os calcis and outer border of the tendo Achillis.

AMPUTATION AT THE ANKLE-JOINT.

Syme's Amputation, Tibio-tarsal Amputation. (Figs. 41, 42, B.) Amputation through the ankle-joint by the cir-

cular method, lateral flap, or a long anterior flap taken from the dorsum of the foot, as proposed by Baudens, did not meet with favor, because the delicacy of the coverings or the vicious position of the cicatrix rendered the stump practically useless; and, although occasional successes were reported, the choice still lay between Chopart's operation and amputation of the leg, until Prof. Syme, in 1843,¹ showed how the excellent plantar flap could be obtained. About the same time Jules Roux, of Toulon, met the same indication by means of a large internal lateral flap carried across the plantar aspect of the heel.

By greatly restricting the necessity for amputation of the leg this operation has become one of the most important and frequently performed of all amputations. The objections urged against it, and the unfavorable results that have sometimes followed its use, seem to have had their origin in a failure to understand or carry out all the details of its execution, or in the introduction of improper modifications. It has seemed desirable, therefore, to reproduce here Prof. Syme's directions for performing it, as published in 1848,² six years after he had first put it into practice.

"Succeeding experience taught me that a much smaller extent of flap than had originally been considered necessary was sufficient for the purpose, and that hence the operation could not only be simplified in performance, but increased in safety from bad effects.

"The foot being placed at a right angle to the leg, a line drawn from the centre of one malleolus to that of the other, directly across the sole of the foot, will show the proper extent of the posterior flap. The knife should be entered close up to the fibular malleolus,³ and carried to a point on the same level of the opposite side, which will be a little below the tibial malleolus. The anterior incision should join the two points just mentioned at an angle of 45° to the sole of the foot, and long axis of the leg. In dissecting the posterior flap, the operator should place the fingers of his left hand upon the heel, while the thumb rests upon the edge of the integuments, and then cut between the nail of the

¹ Lond. and Edin. Monthly Journ. of Med. Science, Feb. 1843.

² Contributions to the Path. and Princ. of Surgery. Edinburgh 1848.

³ The tip of the external malleolus, as on the posterior foot, rather nearer the posterior than the anterior margin of the bone—Syme, in Lancet, 1855.

thumb and tuberosity of the os calcis, so as to avoid lacerating the soft parts, which he at the same time gently, but steadily, presses back until he exposes and divides the tendo Achillis.¹ The foot should be disarticulated before the malleolar projections are removed, which it is always proper to do, and which may be most easily effected by passing a knife round the exposed extremities of the bones and then sawing off a thin slice of the tibia connecting the two processes.

Disarticulation is accomplished by opening the joint in front and dividing the lateral ligaments by entering the point of the knife between the sides of the astragalus and the malleoli.

The essentials of the method, as pointed out by the more recent Scotch writers (Lister, Spence, and Bell), are that the plantar incision should run from the tip of the external malleolus directly across the heel, should on no account incline forward, and should terminate at least half an inch below the tip of the internal malleolus (behind and below, according to Lister). In case the heel is unusually long the incision may even incline backward. It is not only unnecessary, but actually dangerous, to make the flap longer than this, for it then becomes impossible to dissect out the calcaneum without scoring the subcutaneous tissue in all directions, and increasing the chances of sloughing. If the incision is made further back and carried any higher on the inner side, the posterior tibial will be cut before its division into the two plantar arteries.

Erichsen and Lister both claim that the integrity of the posterior tibial is not of great importance, the vitality of the flap depending mainly upon anastomosing branches of high origin which lie quite near the bone. Erichsen² calls attention to the existence of a "branch of considerable size which arises from the posterior tibial artery, about one and a half to two inches above the ankle-joint, and passes down to the inner side of the os calcis," communicating freely above, below, and behind this bone with the peroneal artery on the other side. As these anastomosing loops lie

¹ It is now generally considered better to divide the tendon from above downward, after first clamping, keeping the edge of the knife close to the upper and posterior aspect of the bone.

² Science and Art of Surgery vol. 1 p. 77. Lea Phila. 1873.

much nearer the bone than the skin, great numbers of them will be divided, and the vitality of the flap endangered, unless the edge of the knife is kept close against the bone during the dissection. Lister goes so far as to say that sloughing of the flap is always the fault of the surgeon, and Bell intimates the same thing.

Roux¹ has shown that this close dissection is not without its dangers from the other side. In two of his cases osteophytes developed within the stump from portions of the periosteum left adherent to the flap. The autopsy in one of these cases showed that six osteophytes had formed and become carious within a year after the operation.

A short longitudinal incision through the deep parts along the middle of the plantar aspect of the calcaneum will sometimes render this step of the operation easier, and be less disadvantageous than the employment of great force.

MODIFICATIONS. A. *Internal Lateral Flap.* When the outer side of the foot has been so altered by injury or disease that the heel flap cannot be obtained, a very good substitute may be had in the large internal flap suggested by Jules Roux, and adopted with slight changes by Sédillot, Mackenzie, and others. Prof. Spence says this stump can hardly be distinguished from Syme's.

An incision (Fig. 43) is commenced at the outer side of the tendo Achillis, a little above its insertion, carried straight forward under the outer malleolus, then in a curved line across the instep half an inch in front of the anterior articular edge of the tibia, and backward to a point just in front of the inner malleolus; thence directly downward to the sole, across it obliquely backward to its outer border, and then backward and upward around the heel to the point at which it began. The edges of the flaps are next dissected up for a short distance, the joint entered at the outer side, and the internal flap completed from within outward after disarticulation.

Sédillot's modification of this consists in making the flap more quadrilateral than triangular, by a semicircular incision across the dorsum three finger-breadths in front of the mal-

¹ Bull. de la Soc. de Chirurgie, tom. III. p. 491, 1853

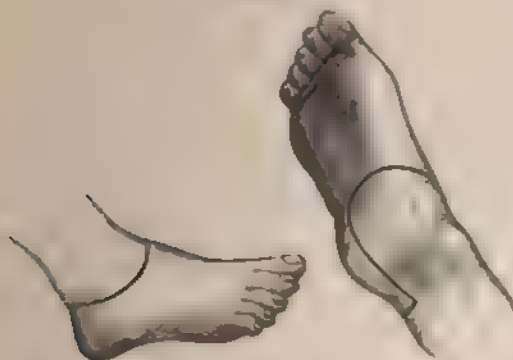
leoli, and by carrying the posterior end of the external horizontal incision across the tendo Achillis to its inner border.

Mackenzie's method differs only in beginning the incision at the inner border of the tendon and a little higher up.

It is probable that a serviceable *external* flap could be made in the same way, although its vascular supply would be scantier.

B. Pirogoff's Amputation. This is a much more important modification, since it involves not merely the method of performing the operation, but also the retention of the posterior portion of the calcaneum, and its ultimate union

FIG. 43



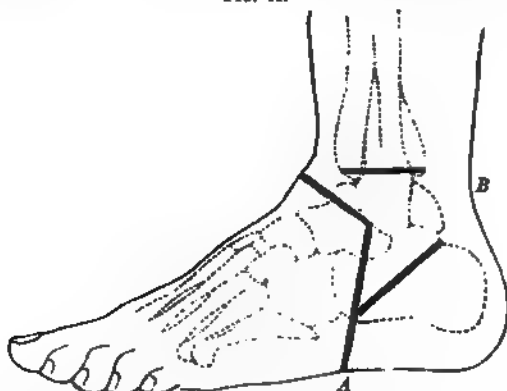
Amputation through the ankle-joint by large internal lateral flap. (Roos.)

with the tibia. The only additional anatomical point that needs mention in connection with it is that the long axis of the calcaneum is directed upward as well as forward.

An incision (Figs. 44 and 45, A) is made from the tip of the inner malleolus to a point a little above and in front of the tip of the outer malleolus, crossing the instep half an inch in front of the anterior edge of the tibia. A second incision crossing the sole at the level of the calcaneo-cuboid articulation unites the extremities of the first, and should be carried boldly down to the bone. The plantar flap is then dissected back for a quarter of an inch, and the dorsal flap to the edge of the joint, the malleoli well exposed, and

the joint opened widely by dividing the lateral ligaments. By drawing the foot forward and depressing it a narrow butcher's or a chain saw can be passed through the joint,

FIG. 44.



Pirogoff's amputation. *A*. Cutaneous incision (outer side). *B*. Line of section of the bones.

FIG. 45.



Pirogoff's amputation. *A*. Cutaneous incision (inner side). *B*. Parallel section of the bones (Sedillot's modification).

and applied to the calcaneum behind the posterior lip of the astragalus, and the bone sawn through downward and forward in such a direction that the section will terminate

half an inch behind the lower edge of the calcaneo-cuboid articulation. The malleoli and a slice of the tibia are then removed as in Syme's operation, and enough of the anterior angle of the calcaneum removed to make the length of its surface of section correspond with that of the tibia. Some surgeons prefer to reverse this order, and remove the malleoli before sawing through the calcaneum.¹

The cut surface of the calcaneum must then be brought up against that of the tibia, and if the section of the former has been sufficiently oblique, and has commenced far enough back, this can be done without making excessive tension upon the tendo Achillis, otherwise another slice must be removed from one of the bones or the tendon divided simultaneously. Suturing together of the bones has been occasionally tried, as has also fastening them together by a long steel pin driven through the skin of the sole and the calcaneum into the tibia.

Several modifications of this operation have been suggested, but they can hardly be considered as improvements. Vertical division of the calcaneum, as originally proposed by Pirogoff and Ure,² deprives the stump of the advantages of the heel pad by swinging the latter too far forward, and bringing the weight of the body upon the thinner skin covering the insertion of the tendo Achillis. It also causes undue tension of the tendon when the bones are brought together. Sedillot suggested an oblique section of the tibia upward and backward, parallel to that of the calcaneum (Fig. 45, B). This avoids any stretching of the tendon, and insures a well-placed pad under the heel, but it shortens the limb somewhat, and places the point of support behind the axis of the leg. Pasquier saws both tibia and calcaneum horizontally; this is difficult of execution, endangers the flap, and also leaves the point of the heel too far back. The suggestion which is occasionally made to retain the malleoli is unsurgical and unprofitable—unsurgical, because union between two cut surfaces of cancellous bone is speedier,

¹ Pirogoff's incisions were nearly identical with Syme's. He also divided the calcaneum vertically and left in the articular surface of the tibia, instead of removing it.

² The conception of the operation seems to have been originally with him. His case was published in the *Lancet* about the time of the appearance of Pirogoff's book at Leipzig, 1861.

stronger, and not exposed to greater risks than when one surface is covered with articular cartilage; unprofitable, because nothing is gained in accuracy of adjustment or length of limb.

Comparison of the Different Methods of Partial and Total Amputation of the Foot. As an offset to the advantage of their less extensive mutilation, Lisfranc's and Chopart's amputations are open to the objection that the unopposed action of the muscles of the calf may raise the heel permanently, and bring the weight of the body upon the end of the stump and the cicatrix; and, furthermore, when these amputations have been performed for disease of the bones, those bones which were left behind, even if entirely healthy at the time of the operation, have ultimately become affected.

Syme's amputation gives an excellent stump, and the shortening of the limb is no more than is necessary to permit the adaptation of an artificial foot and a spring under the heel, but it is comparatively difficult of execution, and the flap is liable to pouch and favor retention of the pus. Pirogoff's method is easier of execution and gives a longer limb, but an artificial foot cannot be fitted to it so advantageously, and in cases of amputation for disease it is contrary to sound principles of surgery to leave in the stump any bone which is apt to become subsequently affected; it brings the heel pad a little too far forward, and requires a longer time for recovery from the operation. The subastragaloid disarticulation gives a longer limb and a good stump, but disease is apt to recur in the astragalus.

(See also Mikulicz's osteoplastic excision of the heel.)

AMPUTATION OF THE LEG.

A. LOWER THIRD. This may be done by the pure circular or by a modified circular method, with a long anterior flap made to overhang the square-cut posterior segment of the limb, or with a long elliptic posterior flap, including the whole of the tendo Achillis. The two former result in a central adherent cicatrix; in all the coverings are liable to be thin and tender, and the artificial limb must be so ad-

justed that the weight will be received by the sides of the leg and not upon the face of the stump. The compensatory

FIG. 46.



FIG. 47.



Fig. 46. Amputation of leg. A Modified circular B, Rectangular flaps, Teale C Antero-posterior flaps, upper third. Bell

Fig. 47. Amputation of leg. A Long anterior flap B Engr's malleolar amputation by long posterior flap Guyon C At the upper third, scissel D Skin flaps and circular division of the muscles

advantages are that the control of the limb is more perfect than with a shorter stump, and the mortality consequent upon the operation less.

1. *Circular Method.* A circular incision is made through the skin, and a cutaneous sleeve one inch long behind, two inches in front, is dissected up; the soft parts are cut straight through to the bone at the base, and then retracted with a two- or three-tailed band, according to the breadth of the interosseous membrane, and the bones sawn through, beginning and ending with the tibia.

*Brun's Method.*¹ While the skin is strongly drawn up, a circular incision is made down to the bone at a distance below the future saw-line equal to two-thirds of the diameter of the leg at the saw-line. Liberating incisions about two inches long are carried upward from the circular incision, dividing all the soft parts over the inner border of the tibia and the outer aspect of the fibula, the latter being reached through the intermuscular septum. Without disturbing the attachments of the overlying soft parts, the periosteum is carefully raised from the tibia and fibula as high as the lateral liberating incisions extend, and first the fibula and then the tibia are sawn through, the latter obliquely to prevent projection of the crest. The vessels are then ligated, the extremities of the tendons excised, and buried sutures passed, uniting the muscles and periosteum, and, after rounding off the corners, the wound is closed with a drain in the upper angle of the lateral incisions.

In the upper half of the leg the circular incision is made first through the skin, and then the muscles are divided a finger's-breadth higher up.

2. *Modified Circular.* Fig. 46, A. Circular incision through the skin, met by a liberating longitudinal one on the antero-external aspect. The soft parts of the posterior portion are divided rather lower than those of the anterior portion, and all are dissected back to the line at which the bones are to be divided.

Instead of a single liberating incision two may be made, one on each side; and then by rounding off the corners we may have double skin flaps with circular division of the muscles, the "modified flap" operation.

3. *Long Anterior Flap* (Bell). Fig. 47, A. An anterior flap, equal in length to the diameter of the leg at its

¹ *Beiträge zur klin. Chir.* 1893, p. 192.

base, is marked out by a curved incision through the skin, beginning at the posterior edge of the tibia on the inner side, a little below the point at which the bones are to be divided, and ending at a point directly opposite over the fibula. The anterior muscles are divided transversely half an inch above the lower end of the flap, and carefully dissected off the bones and interosseous membrane as high as the base of the flap. The separation from the interosseous membrane should be made with the finger or handle of the knife, in order that the anterior tibial artery which lies immediately upon the membrane may not be injured. The posterior flap is then made by transfixion and cutting transversely outward, and, the soft parts being retracted, the bones are sawn across a little higher up.

The resulting cicatrix is posterior and not adherent to the end of the bone. Bell¹ reports five cases, in all of which there was complete and rapid recovery, with a useful stump.

4. *Elliptic Posterior Flap* (Guyon²). Figs. 47 and 48, B. The incision is made in the form of an ellipse, whose lower end crosses the heel below the insertion of the tendo Achillis, and whose upper end is about an inch above the anterior articular edge of the tibia. Beginning at the lower end and dividing the tendo Achillis at its insertion, and hugging the bone all the way, the flap is dissected up posteriorly as high as the upper end of the ellipse.

FIG. 48.



Amputation of the leg at the knee. A. Long posterior rectangular flap. B. Saphenotomical flap. C. At the upper third. D. Dissection at the knee oval incision.

¹ Manual of Surg. Operations, 3d ed., p. 55. Edinburgh, 1861.

² Bulletins de la Société de Chirurgie, 1868, page 37.

The anterior muscles are then divided by transfixion, the bones sawn through, and the posterior tibial nerve resected.

In this operation the sheath of the tendo Achillis is not opened, and the tendon itself serves afterward as a covering for the end of the bone. The retraction of the muscles of the calf tends, in the course of time, to draw the cicatrix downward and backward, and Farabeuf has proposed to meet this tendency by carrying the anterior end of the ellipse still further up the leg, so that that part of the incision through the skin shall be an inch or so above the line of division of the bones and anterior muscles.

B. MIDDLE THIRD. 1. Long anterior curved flap. 2. Simple posterior flap. 3. Skin flap and circular division of the muscles.

1. The *long anterior curved flap* is made according to the method described for its use in the lower third. The principal points to be borne in mind are to separate the anterior muscles from the interosseous membrane with the finger or handle of the knife, to make the flap long enough to fall over and cover the broad posterior surface of section without tension, and to saw off obliquely the prominent angle made by the crest of the tibia.

2. *Single Posterior Flap.* When the muscles have become atrophied a single posterior flap may be safely made. A transverse incision is made across the front of the leg from the posterior edge of one bone to that of the other, and a long posterior flap cut from within outward, by transfixion. Its length should be equal to the diameter of the leg at its base.

3. *Skin Flaps and Circular Division of the Muscles.* Fig 47, D. Longitudinal incisions are made on the anterior and posterior aspects of the leg, midway between the tibia and fibula. They should extend downward from a point about an inch below the future saw-line to a point at a distance from the saw-line equal to two-thirds of the diameter of the leg where the bone is to be divided. These are joined by transverse incisions with the corners slightly rounded. The incisions are carried through the skin and subcutaneous tissue, and the flaps thus formed are turned back, drawn up, and dissected from the fascia, with care to

include all the subcutaneous cellular tissue, till the point of bone division is nearly reached.

The muscles are then cut transversely through to and between the bones, the interosseous membrane divided, a three-tailed retractor applied, and, after circular division of the periosteum, the bones are sawn, finishing with the fibula first. The cicatrix will lie between the tibia and fibula. This is generally the best method for amputation of the leg.

(C. UPPER THIRD. (*"Place of Election."*) The bones should never be divided above the attachment of the ligamentum patellæ to the tuberosity of the tibia, and it is better to divide two inches below it, when possible, so as not to open the sheaths of the flexor muscles of the thigh. Baron Larrey preferred to make the section obliquely upward and backward, beginning at the middle of the attachment of the ligamentum patellæ. He claimed that this could be done without opening the knee-joint, and that the greater vitality of the spongy tissue made recovery more rapid. The head of the fibula should not be removed, because in a certain proportion of cases the upper tibio-fibular articulation communicates with that of the knee. The circular and the various flap methods may be employed.

4. *Long Anterior Rectangular Flap (Trale).*¹ Fig. 46, B. The following two methods have been practically abandoned on account of the great sacrifice of sound parts which they entail. From each end of the transverse diameter of the leg at the point at which the bones are to be divided an incision, equal in length to half the circumference of the leg at that point, is made downward and slightly backward, so that the two shall be as far apart as they are at their upper ends, measuring across the front of the leg. Their lower extremities are then united by a transverse anterior incision carried through to the bones and interosseous membrane. The flap thus marked out is dissected up to its base, the separation from the interosseous membrane being made with the finger or handle of the knife so as not to injure the anterior tibial artery.

¹ See also page 93.

The anterior muscles are then divided by transfixion, the bones sawn through, and the posterior tibial nerve resected.

In this operation the sheath of the tendo Achillis is not opened, and the tendon itself serves afterward as a covering for the end of the bone. The retraction of the muscles of the calf tends, in the course of time, to draw the cicatrix downward and backward, and Farabœuf has proposed to meet this tendency by carrying the anterior end of the ellipse still further up the leg, so that that part of the incision through the skin shall be an inch or so above the line of division of the bones and anterior muscles.

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¹ See also page 93.

A posterior flap, one-fourth the length of the anterior one, is next cut by a transverse incision straight down to the bones, and dissected back to the same point, the interosseous membrane divided, the bones cleaned and sawn through.

The long flap is then doubled back upon itself, its lower end sewed to that of the posterior flap, and the edges of the lateral incisions fastened together.

5. *Long Posterior Rectangular Flap* (Lee). Fig. 48, A. The incisions are similar to those used in Teale's method, but they involve only the skin, and the short flap is anterior, the long one posterior. The posterior flap contains only the gastrocnemius and soleus, while the deeper layer of muscles, together with the large vessels and nerves, is cut transversely as high as the lateral incisions permit.

1. *Modified Flap* (Bell). Fig. 46, C. Two equal semilunar flaps of skin three inches long, one antero-external, the other postero-internal, their extremities meeting at opposite points about two inches below the tuberosity of the tibia. These must be reflected up, and with them another inch of skin, embracing the whole circumference of the limb, must be dissected up. The anterior muscles must be cut as high as exposed, and the posterior ones about the middle of their exposed surface. The bones must then be sawn as high as exposed, the fibula being finished first, and the sharp prominence of the edge of the tibia removed.

Large External Flap (Farabœuf). An incision involving the skin only is begun at the level at which the bone is to be divided, and carried vertically downward close to the inside of the anterior border of the tibia, a distance nearly equal to the diameter of leg at the proposed point of section. Thence, with slightly rounded corners, it passes horizontally across the outer aspect of the leg and vertically up behind, opposite the anterior incision, to terminate an inch and a half below the level of the starting point. After retracting the skin and subcutaneous tissue the deep fascia is cut along the crest of the tibia, and the underlying soft parts separated from the external surface of this bone and from the interosseous membrane mainly by a blunt dissection to avoid wounding the anterior tibial artery, upon which the vitality of the flap largely depends. While the

fingers are inserted in the gap thus made, the muscles are divided obliquely downward and outward to the margin of the retracted skin, thus making the external flap quite thin at its lower edge. The dissection must not be carried high enough to injure the artery where it pierces the interosseous membrane.

The ends of the anterior and posterior incisions are now united by one through the skin, curving slightly downward across the inner aspect of the limb, and the underlying soft parts cut by transfixion at this level and separated from the bone up to the point of the proposed saw-line. The interosseous membrane is then pierced and the periosteum of the tibia divided circularly and the bone bared for a short distance. The fibula is sawed obliquely on its external surface from without downward and inward, the stump being made about half an inch shorter than the tibia. The latter is then cut transversely and its projecting crest and internal border removed.

The anterior tibial artery is divided in the free edge of the external flap, while the posterior tibial and the peroneal arteries lie in the same plane on the tibia's posterior muscle, and are cut transversely close together. The resulting cicatrix is on the inner side of the leg.

COMPARISON OF THE DIFFERENT METHODS.

Amputation in the lower third is less fatal than amputation at a higher point, and gives better command of the limb, but the coverings of the stump are liable to be too thin and tender. The circular and double flap methods formerly gave central cicatrices and stumps that would bear no weight upon their face, and were sometimes so sensitive that even the pressure of a stocking could hardly be borne. Guyon's long posterior flap taken from the heel promises well; in the first case reported the cicatrix, six weeks after the operation, was two inches above the end of the stump, upon which forcible pressure could be made without causing any pain.¹

In a letter to me dated June 1877, Prof. Guyon states that he has amputated four times by this method, and has every reason to be satisfied with the result. The patients bore their weight upon the stump as freely as upon the end of foot. Two cases are reported in the *Bull. de la Soc. de Chirurgie*, 1877, p. 322.—L. A. S.

The long anterior flap also yields a cicatrix which is placed posteriorly and out of the way of pressure, and in short it may be said that the reasons which made the upper third the place of election have lost their force since amputation by a long single flap has been shown to be practicable at any point.

After amputation in the upper third the weight of the body may be borne upon the tough skin below the patella, the patient kneeling upon his artificial leg; or the stump may fit into the hollow end of an artificial limb, the upper edge of which will receive the weight from the lower edge of the patella and the broader bony surfaces near the joint. In either case motion at the joint is preserved, and there is no pressure upon the cicatrix.

In children methods of amputating which retain in the flap a considerable strip of the periosteum of the removed bone are, as a rule, to be avoided, because of the probability of an objectionable formation of bone by it, the so-called "physiological concity."

AMPUTATION AT THE KNEE.

Under this head are ranged pure disarticulations and amputations through the condyles of the femur. In disarticulating, the lateral and crucial ligaments should be divided near their attachments to the femur, and the semilunar cartilages removed.

A. DISARTICULATION. *Long Anterior Flap.* Fig. 49, A. A tongue-shaped flap is marked out by an incision beginning half an inch below the line of the articulation nearly as far back as the posterior border of the condyle on one side, and ending at the corresponding point on the other, after crossing the leg five inches below the patella. A transverse posterior incision unites the sides of the first an inch below its ends. The flap is dissected up and the disarticulation completed as before.

Prof. Pancoast has modified the operation by making inside of a single short posterior flap two small semilunar postero-lateral ones, meeting in the centre of the popliteal space.

Lateral Flaps (Stephen Smith¹). "Commence an incision about an inch below the tubercle of the tibia and cut to the bone; carry it downward and forward beyond the curve of the sides of the leg, thence inward and backward to the middle of the leg, thence upward to the middle of the popliteal space; repeat this incision upon the opposite side; raise the flap consisting of all the tissues down to the bone; until the articulation is reached divide the lateral ligaments, enter the joint and sever its connections internally and externally."

B. AMPUTATION THROUGH THE CONDYLES. *Oval Method.* An oval incision crossing the front of the leg three finger-breadths below the end of the patella and the back three finger-breadths higher than in front is made through the skin, which is reflected, and the joint opened above instead of below the patella, which is not included in the flap. The line of incision is similar to that in Fig. 48, *D*, but higher. After disarticulation has been effected, the posterior soft parts divided, and the artery tied, the condyles are sawn through above the edge of the articular cartilage. Or the saw may be applied without having previously disarticulated.

Anterior Flap (Carden²). Fig. 49, *B*. "The operation consists in reflecting a rounded or semi oval flap of skin and fat from the front of the joint; dividing everything else straight down to the bone; and sawing the bone slightly above the plane of the muscles: thus forming a flat-faced stump with a bonnet of integument to fall over it.

"The operation is simple and is performed easily in two ways.

"The operator, standing on the right side of the limb, seizes it between his left forefinger and thumb at the spots selected for the base of the flap, and enters the point of his knife close to his finger, bringing it round through skin and fat below the patella to the spot pressed by his thumb; then turning the edge downward at a right-angle with the line of the limb, he passes it through to the spot where it first entered, cutting outward through everything behind the

¹ Smith's Operat. Surg., p. 627.

² British Med. Journal, April 16 1864.

bone. The flap is then reflected, and the remainder of the soft parts divided straight down to the bone;¹ the muscles are then slightly cleared upward, and the saw is applied.

FIG. 49



Amputation at the knee and lower third of thigh. *A* Disarticulation—long anterior flap. *B* Amputation through the condyles, Carlen. *C* Modified flap amputation at the lower third of the thigh, Syme.

"Or the flap may be reflected first and the knee examined, particularly if the operator be undecided between resection and amputation. In amputating through the condyles, the patella is drawn down by flexing the knee to a right-angle before dividing the soft parts in front of the bone; or if that be inconvenient the patella may be reflected downward.

"The flap falls easily over the end of the bone, and, when united to the posterior integuments by a few pins and sutures, is drawn strongly upward and backward by the greatly retracted flexors, and has a somewhat puckered and redundant appearance at first.

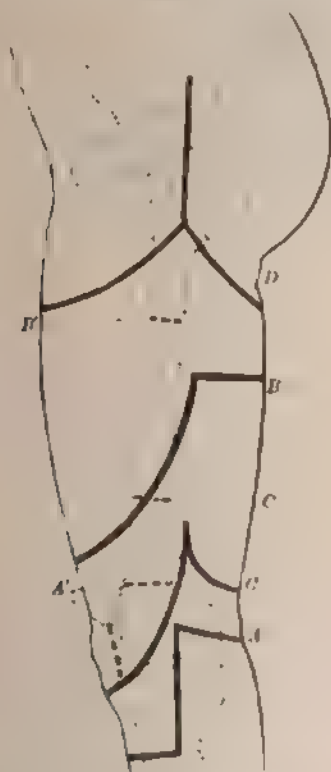
Griffi's Modification. This is the analogue of Pirogoff's modification of Syme's amputation at the ankle. The articular surface of the patella is removed and the cut surface of the bone applied against that of the femur. The natural mobility of the skin over the patella is preserved, and the usefulness of the stump increased thereby; but it not unfrequently happens that the patella is drawn upward by the quadriceps femoris,

and union does not take place between the two bones. Griffi sawed through the femur at the upper edge of the articular surface, but I have always found it advisable to

¹ Lister and Bell recommend a posterior skin flap one inch long.

go nearly an inch higher in order to prevent tilting of the patella. Von Lohart¹ claims that the stump is better than

FIG. 60.



A Griffith's amputation at the knee; *A'* Lines of division of the bone. *B* Long anterior flap—~~not~~. *B'* Division of bone. *C* Amputation at lower third of femur, *C'* Division of the bone. *D* Disarticulation at the hip.

that obtained by amputation in the lower third of the femur, but not better than that obtained by disarticulation.

A rectangular anterior flap (Fig. 50, *A*) extending from

¹ Compend v. Operativechirurgie, 1867, p. 401

the centre of the condyles to the tuberosity of the tibia is marked out, and dissected up after division of the *ligamentum patellæ* as near as possible to its insertion; the skin covering the back of the knee is divided transversely, or by an incision curved slightly downward, the anterior flap turned back, the synovial membrane separated from its attachment to the femur, and the bone sawn through well above the edge of the articular cartilage, but below the medullary canal. The remaining soft parts are then divided from within outward, and the vessels secured. The articular surface of the patella may be sawn off or removed with cutting-pliers, and this step in the operation is facilitated by having the *ligamentum patellæ* cut long, so that it can be used to hold the bone firmly.

AMPUTATION OF THE THIGH.

The central position of the femur, and the abundance of the soft parts, have made it possible to employ a great variety of methods of amputation, but the superiority of the flap operation is now generally admitted, with certain modifications depending upon the portion of the limb selected for amputation. Thus, in the lower third when the skin over the patella is uninjured, Teale's or Carden's method is to be preferred; when, on the other hand, that portion of skin is unavailable, the long anterior flap, or Syme's modified flap operation, should be used; and in order to compensate for the greater retraction of the posterior muscles they should be cut obliquely instead of transversely in the former operation, and on a lower level than the anterior muscles in the latter. In the middle third the long anterior flap is to be preferred. Lateral flaps should always be avoided on account of the tendency of the bone to project at the upper angle, drawn forward, as it is, by the action of the flexors of the thigh upon the pelvis.

The muscles are more abundant on the inner and posterior aspects, and this disproportion increases toward the hip. The femoral artery will be found in the posterior flap below the middle of the thigh, in the anterior flap above; care must be taken not to include the internal

saphenous nerve in the ligature placed upon it. The profunda artery lies close behind the bone, but divides early into its branches. The sciatic nerve lies between the short head of the biceps and the adductor magnus; it should be drawn gently downward and divided again high up.

Sometimes the band of the tourniquet prevents the muscles from retracting sufficiently to allow the bone to be cleared to the proper height. Under such circumstances the bone should be divided wherever it is most convenient, and the excess sawn off after the vessels have been tied.

Teale's and *Curden's* methods have been sufficiently described. (See pp. 70, 111.)

Modified Flap Operation in the Lower Third (Syme). (Fig. 49, C.) Two equal semilunar flaps of skin and fat, one anterior, the other posterior, are made, raised from the fascia, and retracted two inches further; "the muscles should then be divided right down to the bone, on a level as high as they are exposed in front, as low as they are exposed behind." The bone is then cleared and sawn through two inches above the level of division of the anterior muscles.

Long Anterior Flap. Sédillot,¹ writing in 1854, says he has used this method exclusively for the preceding seven years. Spence² describes a method as first practised by himself in 1858, and claims that his "flap is formed on a principle essentially different from that which regulates the construction" of Sédillot's, a difference which is not recognizable in the descriptions, the length of the flap in each case being equal to the diameter of the limb, the breadth of its base "almost two thirds of the circumference" according to Sédillot, "fully equal to one-half the circumference" according to Spence, and the muscle contained in it cut obliquely by both, so that it shall not be too thick. Sédillot divides the posterior segment of the limb transversely. Spence divides it obliquely from without inward, beginning two inches below the base of the anterior flap, and some-

¹ *Medical Operators*, 3d edition, vol. 1, p. 465.

² *Lectures on Surgery*, 2d edition, vol. II, p. 621, Edinb., 1858.

times takes an additional inch of skin, a difference which approximates his method to Teale's. Benjamin Bell also describes a method which is nearly identical, and O'Halloran used a similar one in 1765, but his flap was too short to accomplish its purpose.

Séclillot's description is as follows (Fig. 50, B):

The flesh of the anterior aspect of the limb is grasped in the left hand, and an incision made through the skin, marking out a flap whose length is equal to one-third, and its base to almost two-thirds of the circumference of the limb. The muscles are then divided obliquely upward and backward so that the flap shall not be too thick, the posterior segment of the limb divided transversely, the bone cleared an inch or two higher and sawn through. He also removes the anterior edge of the bone obliquely, as was recommended for the tibia.

Spence recommends the long anterior flap as especially applicable to amputation in the lower third, and he makes it as low as possible, so that its lower margin is on a level with or below the patella. After dissecting up the skin to the upper end of the patella, he cuts obliquely upward through the anterior muscles to the bone immediately above the condyles (Fig. 50, C). While the soft parts are retracted, and after the bone has been cleared circularly, he elevates the femur so as to project it fully, and divides it two inches above the base of the flap.

Modified Circular Amputation in the Lower Third. The incision, involving only the skin, is begun at the outer part of the anterior surface of the thigh, at a distance below the proposed saw-line equal to one-quarter of the circumference of the limb at the level where the bone is to be divided. It is carried obliquely downward across the front of the thigh, and then transversely across the inner and posterior aspects at a distance below the proposed saw-line equal to one-third of the circumference already taken, and finally upward on the outer aspect to the point at which it began. The skin is next retracted and freed all around for about two inches.

The superficial muscles on the inner and posterior aspects of the thigh are divided at the level of the retracted skin,

and then the outer and deeper muscles are severed down to the bone at the highest possible level.

In cutting the muscles the obliquity of the original incision is to be maintained. Retractors are now applied and the bone sawed, taking care not to leave a projecting spike at the *linea aspera*.

AMPUTATION AT THE HIP-JOINT.

The affections which render this most serious operation necessary are often of such a nature that the surgeon's choice of a method of performing it is greatly restricted; he must take his flaps where he can get them, and must regulate his incisions by existing lesions. Moreover, the problem is not to obtain a flap that will bear pressure, but to remove the limb in the manner that involves the least risk to life. This risk, which has proved very great, is due not only to the gravity of the lesions which render surgical interference necessary, but also to three causes which originate in the operation itself. These are loss of blood, shock, and septicæmia. The first two are the principal dangers, as modern methods have minimized the chances of infection, although formerly they were considerable.

The opinion, held by many, that the amount of shock varied directly with the length of time employed in removing the limb, led to the introduction of operative methods characterized by extreme rapidity of execution, not more than thirty seconds being allowed for the removal of the limb from the body; the type of these is the method by a long anterior flap made from within outward by transfixion.

To prevent hemorrhage many expedients have been employed: the same rapidity of execution; compression of the femoral artery upon the pubis, or within the flap by an assistant, who passes his fingers into the wound behind the knife; compression of the aorta; preliminary ligature of the femoral artery; ligature of each vessel when encountered in the wound; laparotomy and digital compression or ligation (q. v.) of the common iliac; compression by an elastic tourniquet applied above steel pins thrust through the thigh. The hemorrhage most to be feared is that from

the numerous vessels of the posterior segment of the thigh, for, while the femoral artery can usually be controlled without much difficulty, there is no way of preventing the flow of blood from the others except by compression of the aorta or common iliac through the walls of the abdomen, or of the interval iliac through the rectum, or by previously securing the common iliac either extra- or intra-peritoneally. The latter device, first suggested as a means of hemostasis during operation for gluteal aneurism, has been employed in one or two amputations with success; compression of the aorta, although effectual and entirely harmless in some cases, has proved dangerous or impracticable in others¹ by exciting peritonitis or interfering with respiration.

A simple, efficient, and probably safe method is one recently devised and successfully employed by Dr. McBurney; direct compression of the common iliac artery by the finger introduced through an incision in the anterior abdominal wall.

Dr. Wyeth² uses two steel mattress-needles which are thrust through the thigh to prevent the slipping of an elastic tourniquet fastened above them. After applying the Esmarch bandage from the toes to the groin the first needle is entered one and a half inches below and just to the inner side of the anterior superior spine of the ilium. It passes externally to the neck of the femur, and comes out just behind the great trochanter about half-way between it and the posterior superior iliac spine. The second needle is entered an inch below the level of the groin internal to the saphenous opening, and, passing through the adductors, emerges about one and a half inches in front of the tuber ischii. A stout rubber tube is then wound tightly enough around the thigh above these pins to occlude the vessels.

Dr. McBurney has also used in two cases, and apparently with great advantage, intra-venous injection of a large quantity of normal salt solution during the operation.

The position of the joint may be determined by that of the anterior inferior spine of the ilium, which is three-quarters of an inch above its upper margin.

¹ See Ewing Mason, "Two Successful Cases of Amputation at the Hip-joint," *N. Y. Med. Jour.*, Dec. 1876.

² *Journal Am. Med. Assoc.*, Feb. 7, 1891.

Nearly all of the numerous methods for performing amputation at the hip-joint may be considered as variations to a greater or less extent from the operation by flaps, which may be either external and internal or anterior and posterior, and by the anterior and the external oval—sometimes called racket—incision. Disarticulation by external and internal flaps is not to be commended except for cases in which sound tissue cannot be obtained elsewhere. The knife is entered about a hand's-breadth vertically below the anterior superior spine of the ilium and made to transfix the thigh from before backward just below the great trochanter; it is then carried down and out, cutting a flap four or five inches long. The muscles are then separated from the great trochanter, and after disarticulation the inner flap is cut of a similar length. Hemorrhage is controlled by the pressure of an assistant's fingers entered in the track of the knife and by ligation of each vessel as soon as possible after it is divided.

When the nature of the disease or injury permits, the operation by the external racket incision is generally given the preference. In this the bone is approached through the least vascular area, and the incision can also be used for exploration before proceeding to amputation.

1. *Anterior Racket or Oval Method.* The patient having been anesthetized and placed upon the table, an Es-march's elastic band is applied from the toes as far upward as is allowed by the nature of the lesion and the line of the proposed incision.

1. An incision, beginning a finger's-breadth below Pon-part's ligament, is carried down along the course of the femoral artery for about four inches; thence outward and downward, crossing the great trochanter a little below its base, to the gluteal fold; thence transversely along this fold to the inner side of the thigh, and thence obliquely upward five full finger-breadths below the genito-crural fold to the point where it diverged from the line of the artery. The incision should involve only the skin and the cellular tissue; any vessels that are divided should be immediately tied.

2. The sheath of the vessels is opened, the artery isolated

and denuded, and its point of bifurcation determined. A ligature is then applied methodically to the vessel above the origin of the profunda, and a second lower down, including both branches *en masse*, and the artery divided between them. The femoral vein is also carefully denuded and divided between two ligatures at about the same level.

3. The incision is carried down through the muscles, beginning on either the outer or inner side, as is most convenient; on the inner side, after having cut through the adductors at the junction of their fleshy and tendinous portions, seek and tie the obturator vessels, divide the pectineus and psoas on a line with the neck of the femur, and secure all the bleeding points. On the outer side, divide the sartorius and the fascia lata, and then adduct the thigh so as to throw the great trochanter forward and facilitate the division of the muscles attached to it.

4. Open the articulation in front and divide the posterior portion of the capsule as close as possible to the femur, together with the remaining tendons that are inserted in the great trochanter.

5. Division of the posterior segment of the limb. Depress the thigh beyond the border of the table, so as to make the wound gape widely, and divide the remainder of the adductors and the muscles attached to the ischium with gentle strokes of the knife, tying each vessel when it is recognized or divided. It is well also to resect the extremity of the sciatic nerve.

II. *External Racket Incision or Modified Oral Method.* Fig. 50, D. The patient is laid upon his side, his hips at the foot of the table. A straight incision four inches long is begun one inch above the summit of the great trochanter, and carried along its posterior border, and a circular incision is then carried from the lower end of the first around the thigh, passing three inches below the tuberosity of the ischium. These incisions should interest the skin only, their borders should be dissected up for about an inch, and the muscles of the outer aspect divided obliquely upward toward the joint. In front this division should not be carried beyond the outer edge of the rectus muscle, but pos-

teriorly it should be as extensive as possible and close to the bone.

The thigh being flexed and adducted, the capsule is opened, first longitudinally on the finger as a guide, then forward and backward along the edge of the cotyloid cavity, the head of the femur dislocated backward and outward, the knife passed around it and brought down along the inner side of the bone nearly to the level of the circular incision, and then made to cut its way rapidly out on the inner side.

Esmarch's method differs slightly from this last. Hemorrhage is controlled by digital pressure on the femoral in the groin. Five inches below the top of the great trochanter divide everything circularly down to the bone, which is at once sawn across. The vessels are then secured. Next the stump of the femur is steadied and the knife entered about two inches above the tip of the trochanter and carried down along its outer surface till it reaches the first circular incision. The bone is freed from soft parts by an elevator entered beneath the periosteum, aided by the knife, the muscular insertions on the trochanters divided, the capsule opened, and the bone removed.

III. *Anterior Flap.* The position of the patient being the same, and the thigh slightly flexed and abducted, the point of a long amputating-knife is entered midway between the anterior superior spine of the ilium and the top of the great trochanter and passed inward and backward to a point one inch below and in front of the tuberosity of the ischium, grazing the anterior surface of the neck of the femur, and certainly opening the capsule of the joint if its edge is kept turned obliquely toward it. (The direction may be reversed for the right thigh, the knife being entered on the inner side.)

A well-rounded flap ending at the junction of the upper and middle thirds of the thigh is then cut with rapid sawing movements of the knife, and reflected upward. The limb is forcibly depressed, and if the capsule has been well divided this movement will throw the head of the femur forward out of the socket; and if not, a single cut with the knife across the head of the bone will free it. The leg is

then rotated inward so as to bring the trochanter forward, the surgeon passes the knife behind the head of the bone and cuts a short posterior flap from within outward.

Prof. Van Buren divided the posterior segment from without inward by a sweep of the knife as in a circular amputation, and then disarticulated and divided the rotator muscles with a scalpel.

In the flap operation by transfixion the assistant who compresses the artery against the pelvis with one hand should follow the knife with the other, and grasp the vessel in the flap between his fingers and thumb, and his control of it should be such that the surgeon can give his attention first to securing the numerous vessels of the posterior segment, the bleeding from which may be partly checked by pressure with dry sponges or cloths while the ligatures are being applied. Or the bleeding points may be caught up rapidly with artery-forceps, and the ligatures not applied until after all have been thus secured.

*Senn's Bloodless Method.*¹ Start an incision on the outer surface of the thigh about three inches above the trochanter, and carry it vertically downward for about eight inches, exposing the outer surface of the trochanter and femur.

Keeping close to the bone, separate the muscular attachments to the great trochanter, and, while the thigh is flexed, adducted, and rotated inward, open the capsule transversely at its upper posterior aspect. Sever the rest of the ligaments by backward dislocation of the head of the femur, which is then pushed out of the wound and the lesser trochanter and shaft freed as low as desired.

A sinus-forceps carrying a long stout piece of rubber-tubing is pushed through the wound behind the femur at the normal level of the lesser trochanter, emerging through a small counter-opening on the inner surface of the thigh, where the tube is cut apart and the vessels occluded by tying the anterior segment in front without including the femur; after crossing the posterior segment behind it is brought around the back of the thigh and then tied in front above the anterior segment of tubing. Starting from the

¹ Chic. Clin. Rev., Feb. 1898, p. 243.

points of emergence of the tourniquet a long anterior and a short posterior flap are raised, consisting of all the tissues down to the muscles, which are then cut circularly in the form of a cone with its apex at the lower limit of denudation of the femur. The thigh is thus removed, and after ligating all visible vessels with catgut and excising about an inch of the exposed sciatic nerve the tourniquet is loosened from the posterior flap first and then the anterior.

When the hemorrhage has been entirely checked the wound is closed with interrupted sutures and dressed antiseptically, with drainage in its most dependent angles.

Circular Method. The patient lying upon his back with his thigh overhanging the end of the table, a circular incision is made through the skin, six inches below the anterior superior spine of the ilium, the skin retracted, and the muscles divided successively at higher levels, until the femur is reached. The capsule is then divided in front and on the sides, close to the edge of the cotyloid cavity, the head of the femur dislocated forward, the knife passed behind it, dividing the ligamentum teres, the remainder of the capsule, and the muscles attached to the neck and trochanter.

PART IV.

EXCISION OF JOINTS AND BONES.

Excision of a joint may be (1) *complete* or (2) *partial*. In the former case the articular ends of all the bones composing it are removed; in the latter, one or more are retained. Again, partial excision may consist of (1) partial or (2) total resection of the articular end of one of the members of the joint. The former is often unadvisable; the latter, to which Ollier¹ has given the name of *semi-articular resection*, has given good results in traumatic cases, and of late also, under antiseptic treatment, in tuberculous affections when the disease is still restricted to a portion of the bone and capsule.

Excision of a bone may be *total* or *partial*, and, in the case of the long bones, with or without either or both epiphyses.

The term *resection* is often employed as a synonym of excision. In the narrower sense it refers to the removal of a portion of a bone, including, however, its entire thickness; thus, a joint is excised by the resection of the bones composing it.

Joints are excised on account of injury, disease, or ankylosis in a faulty position; and with the object of obtaining a movable joint, as in the upper extremity, or ankylosis, as at the knee and ankle. The operative procedures may vary with these causes and these objects. Thus, when ankylosis is sought for, the division of the muscles and tendons about the joint is of no special moment; but if the joint is to be re-established, the muscles which control its movements must not be disabled. In any case the main

¹ Congrès Medical de France, 4th session, 1872, p. 234, and Bull. de la Soc. de Chirurgie, 1873.

bloodvessels and nerves must be respected; the incisions, whenever practicable, should be parallel to the long axis of the limb; and when it is necessary to divide a tendon or muscle, the line of section should be oblique rather than transverse, so as to favor reunion.

The incisions should be sufficiently free to allow the bone to be thoroughly inspected with a view to the removal of all the diseased portion. It is better to make a clean division with the saw than to remove the bone piecemeal, but the use of the gouge is proper for the removal of small circumscribed areas of disease found upon the surfaces of section, and even very extensively in the young, as a substitute for a formal excision in order not to diminish the subsequent growth of the limb by the destruction or removal of the epiphyseal cartilage.

The synovial membrane in traumatic and non-tuberculous suppurative cases does not require special attention; in tuberculous cases and when much thickened it should be cut or scraped away so as to remove such foci of infection as may exist within its walls or in the fungous granulations on its surface. When ankylosis is sought for, as at the knee, it is prudent to dissect out the sac entirely. If any portion is necessarily left, the destruction of the foci should be sought by thorough scraping, washing with a solution of chloride of zinc, 1 to 30 or 40, or of corrosive sublimate, 1 to 1000, or by the actual cautery.

The propriety of retaining the periosteum is still a subject of discussion, and one in which the decision will probably vary with the articulation and the circumstances of the case. Certain facts have, however, been already established. Its retention is a safeguard against injury to neighboring tissues during the operation; after excision of a bone it gives firmness to the cicatrix, diminishes the shortening of the limb, and insures the proper attachment of the muscles; and in the case of an articulation, if its relations with the capsule are maintained (*periosteal-capsular excision*), it favors the reproduction of the joint with articular cartilages and ligamentary support. On the other hand, the reproduction of bone is not always desirable, and may be excessive or irregular, unduly limiting the motions of the joint, or even causing ankylosis; and, finally, the

bruising received by the periosteum during the operation may cause it to slough, or the reproduction of bone may fail entirely.

Von Langenbeck¹ has shown that in excision of the shoulder-joint it is of the utmost importance to preserve the relations of the periosteum, the capsule, and the tendons of the capsular muscles, but in all other joints, except perhaps the hip, the importance is not so great or, at least, so well established. Complete restoration of the shoulder-joint and re-establishment of the control of the muscles over it have never been accomplished except by the subperiosteal method. The periosteum can be removed without difficulty except when it is actively inflamed; its connection with the bone is very slight in cases of chronic osteitis and synovitis. The tendons, on the other hand, are so firmly attached to the bone that the elevator, or rugine, is sometimes insufficient to remove them properly, and the knife must then be used, its edge being kept as close as possible to the bone. Von Langenbeck goes so far as to say that the success of a periosteal-capsular excision depends in great part upon the proper alternation in the use of the knife and elevator.

Vogt and K nig strongly recommend that, instead of separating the tendons and ligaments from the bone, the latter should be cut through with a chisel so as to leave a shell attached to the soft parts. In children, where the epiphyses are still cartilaginous, this section can be made with the knife.

Excision of single bones may be required on account of injury or disease. The latter is by far the most common cause, and its most common examples are caries of the small spongy bones and necrosis of the long ones, due to acute osteomyelitis or periostitis. The incisions should be made from the side where the coverings of the bone are fewest and of least importance; the periosteum should be left behind, and all the diseased bone should be removed. When the entire shaft of the bone has become necrotic, it must be divided with the chain-saw or cutting-pliers, and each piece pulled or cut away from its epiphysis.

¹ Archiv f r klinische Chirurgie, vol. xxi.

In cutting down upon carious bone or a sequestrum it is well to keep a probe in the sinus leading to it, as it is sometimes difficult to find the hole in the bone after the blood has begun to flow.

MAJOR ARTICULATIONS.

EXCISION OF THE SHOULDER-JOINT.

As formerly performed, excision of the shoulder-joint was an operation the results of which, to quote Holmes,¹ were "probably inferior—certainly not superior—to those of natural ankylosis." If ankylosis did not follow, the joint was loose, under slight control, and, at the best, could not be raised above the horizontal line. Ollier² and Von Langenbeck,³ however, have shown that the periosteo-capsular method furnishes a much larger measure of success. In a case operated upon by the former, where four inches of the humerus were removed, the ultimate shortening was only half an inch, and the motions were quite full; and the latter reports several cases in which the arm could be raised to the vertical line, and the control of the limb was perfect. In all of Von Langenbeck's cases the operation was undertaken on account of gunshot-injury.

As the capsular muscles are attached to the greater and lesser tuberosities, the capsule and periosteum must be divided between these two bony prominences—that is, in the direction of and near to the tendon of the long head of the biceps. An anterior incision beginning at the acromioclavicular triangle is the best one for this purpose, and has, moreover, the advantage of sparing the posterior circumflex artery and the nerve. The cephalic vein lies in the groove between the deltoid and pectoral muscles, and is avoided by making the incision incline outward. When the soft parts are much thickened and consolidated, this incision needs to be supplemented by a short transverse one (Fig.

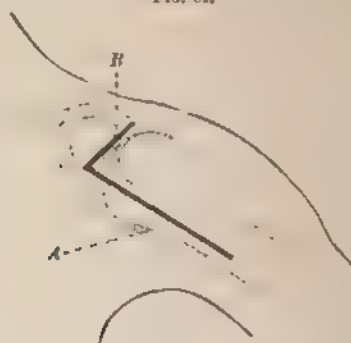
¹ *Surgery: Its Principles and Practice*, p. 929. Lea, Phila., 1875.

² *Traité de la Régénération des os, et des Résections des Grandes Articulations*, 747.

³ *Archiv für klinische Chirurgie*, 1871, vol. xvi.

51, *B*) running outward from its upper end parallel to and just below the edge of the acromion, dividing the fibres of the deltoid transversely in its course; sometimes the condition of the parts is such, and the sinuses so placed, that a

FIG. 51.



Excision of the shoulder (Ollier). *A*. Regular incision. *B*. Supplementary.

large external flap, with its base directed upward, has to be made by a triangular or curved incision, and raised up so as freely to expose the outer aspect of the head of the humerus. In any case the trunk of the posterior circumflex artery should be spared. It is imbedded in loose cellular tissue, and when cut may retract so far that a ligature cannot easily be placed upon it.

The condition of the glenoid cavity seems to affect the prognosis seriously. In eight fatal cases collected by Hodges,¹ it had been interfered with in all but one. Consequently it should not be touched unless actually diseased, and the interference should, if possible, be limited to the use of the gouge.

Spence makes a counter-opening behind for drainage, but this seems to be unnecessary.

Operation (Ollier). Fig. 51. The arm is adducted and rotated inward. The point of the knife is entered at the base of the coracoid process, and carried four inches down-

¹ *Excision of Joints*, Boston, 1861.

ward and outward in the general direction of the fibres of the deltoid, or as much further as may be necessary. The incision thus made will be external to the inner border of the deltoid, and should comprise all the tissues down to the bone.

The edges of the wound are held apart with retractors, and the capsule and periosteum are divided along the outer edge of the tendon of the long head of the biceps and the bicipital groove to the full extent of the external incision. The outer edge of the incision is raised, and the periosteum, together with the capsule and tendons of the muscles inserted upon the greater tuberosity, is carefully detached with the elevator and knife, while an assistant rotates the arm inward to increase the extent of and facilitate the dissection.

The tendon of the biceps is then raised from its groove and held out of the way, the arm rotated outward, and the periosteum, capsule, and tendon of the subscapularis dissected off in the same way on the inner side.

The head of the humerus is then dislocated forward, the posterior attachments of the capsule separated with the elevator or knife, the periosteum peeled off the posterior face of the neck and shaft of the humerus, and the bone sawn through transversely with an ordinary or a chain-saw.

If the articular surface of the glenoid cavity is affected, it must be scraped; if the bone itself is diseased, it should be gouged out until healthy bleeding bone is reached, or the neck may be cut through with strong cutting-pliers after removal of its periosteum.

Von Langenbeck's method differs slightly from the above. He begins his incision at the anterior border of the acromion just outside of the acromio-clavicular junction, and carries it directly downward, the arm being so held as to bring the outer condyle of the humerus in front. This sacrifices the inner fibres of the deltoid by severing their nerves. He carries the incision through the muscle down to the capsule and bone, then raises with pronged forceps the sheath of the tendon of the biceps, which presents in the line of the incision, and opens it carefully from without inward. As soon as the shining tendon is seen he slits

the sheath throughout the entire length of the incision, opening the capsule quite up to the acromion, and exposing the articular end of the humerus with the tendon lying upon it.

He then raises the periosteum on the inner side until the lesser tuberosity is reached, lays aside the elevator, and peels off the tendon of the subscapular with knife and pronged forceps, taking the greatest pains to maintain its relations with the capsule and periosteum. After this dissection has been carried as far as possible on the inner side, he lifts the tendon of the biceps from its sheath, carries it inward, drops it into the joint, and denudes the bone on the outer side with the same precautions, using the knife instead of the elevator to detach the capsule, tendons, and ligaments. The rest of the operation as above.

If only the articular head of the bone is to be resected, near the upper end of the tuberosities, there is no periosteum to be removed. The ligamentous and muscular attachments are approached from within the joint, and the bone divided with the chain or keyhole saw, without raising it from its place.

By a Transverse Incision. (Nélaton, Perrin) A transverse incision three and a half or four inches long is made parallel to and half an inch below the edge of the acromion, beginning in front between it and the coracoid process. The fibres of the deltoid are divided close to the acromion, and by their retraction expose the capsule largely.

The capsule is divided along the outer edge of the tendon of the biceps, and then transversely in the direction of the external wound; the bone is approached and denuded through this opening, and the operation completed as before.

The vessels and nerves are well protected by this method, but it is very difficult of execution.

Excision of the Head of the Scapula. When the disease is confined to the glenoid cavity and the neck of the scapula, the affected parts can be removed by a longitudinal posterior incision extending from the base of the acromion to the fold of the axilla.

EXCISION OF THE ELBOW-JOINT.

Partial excision of the elbow-joint for disease, even when the portions left behind are entirely healthy, is more dangerous and gives as a rule less satisfactory results than complete excision. The humerus should be sawn through at or just above the epicondyles, the ulna at the base of the coronoid process, and the radius through its neck. The extent of the disease may make it necessary to surpass these limits, but the result will then be less perfect, and in any case every effort should be made to preserve the continuity between the periosteum and the tendons of the brachialis anticus and biceps so as to provide for future flexion of the forearm. An exception to the rule of total excision may be found in the preservation under some circumstances of all the olecranon except its articular surface; the joint thus obtained is firmer, and active extension more powerful.

Reproduction of bone takes place less completely at the elbow-joint than at any other of the major articulations, and consequently the greater the amount removed the greater the danger of the formation of an imperfect, loose, and inefficient joint, even when the subperiosteal method has been thoroughly carried out. Von Langenbeck¹ removed four and a half inches of the humerus and two inches of the ulna subperiosteally in a case of gunshot-injury, and says the result was the worst he ever saw, the connection between the arm and forearm being so very loose that the patient was obliged to use a supporting brace, by the aid of which he was able nevertheless to make excellent use of his hand. Ordinarily ankylosis is to be preferred to a very loose joint.

In cases of gunshot-injury Von Langenbeck and Ollier remove as little as possible, making a partial (semi-articular) excision when either the humerus or the bones of the forearm alone are injured. The English authors think the danger in cases of excision for disease is rather of removing too little than too much, and recommend that the humerus be sawn through above the condyles.

As the joint is covered anteriorly with soft parts, among

¹ Loc. cit., p. 443.

which lie nearly all the principal arteries and nerves, and is almost subcutaneous posteriorly, it must be approached from the latter side, and the incisions must be made with especial reference to the safety of the ulnar nerve, where it runs between the olecranon and the epitrochlea. The original method, and the one used almost exclusively for many years, was the H-incision, composed of two longitudinal incisions connected midway by a transverse one crossing the tip of the olecranon. It has the disadvantage of dividing the ulnar nerve or exposing it in the wound if suppuration occurs, and, having been superseded by less complicated ones, does not need to be described.

Although excellent joints have been obtained by the old operations the preference should be given to the modern subperiosteal method, not only on account of the greater certainty of the re-establishment of a useful limb, but also because the danger of diffuse inflammation and purulent infiltration is much less when it is employed. These dangers are greater at the elbow than at any other joint, except the hip, and secondary amputation is more frequently required.

The other methods have been devised with the view of sparing the nerve, preserving the attachment of the triceps and the continuity of the lateral ligaments with the periosteum, and facilitating the operation. Although the central longitudinal incision has been extensively used the preference seems now to be due to methods of approach from the radial side, such as Ollier's, Nélaton's, and Hueter's.

Central Longitudinal Incision. Fig. 52, A. (Von Langenbeck.) The forearm being slightly flexed, a longitudinal incision $3\frac{1}{2}$ inches long is made a little to the inner side of the median line of the triceps and ulna, and carried down to the bone. The inner edge of the divided periosteum is raised from the ulna, the corresponding half of the tendon of the triceps detached with it, and the dissection continued toward the internal condyle, the knife being kept constantly against the bone, and the flexion of the arm increased as the dissection advances. As the epitrochlea is approached the greatest care is needed to preserve the connection between the periosteum, the muscular attachments, and the

internal lateral ligament, and it may be necessary to prolong the first incision upward so as to get more room.

After the inner half of the joint has thus been laid open and the epitrochlea bared, the soft parts are replaced and a similar dissection made upon the outer side with the same precautions.

The humerus is then dislocated backward through the wound and sawn through at, or as near as possible to, the epicondyles, according to the lesion. If the condition of the soft parts does not allow of this projection of the humerus, the chain or keyhole saw must be used.

The ulna is then cleaned circularly as far as necessary and sawn through, and the head of the radius removed with the saw or cutting-pliers.

*Ollier's Method.*¹ (Fig 52, B.) The forearm is slightly flexed, and an incision is commenced two inches above the tip of the olecranon on the outer side of the arm at the interstice between the triceps and supinator longus. This incision, involving the skin only, is carried downward to the epicondyle, thence downward and inward in the line of the upper border of the anconeus to the olecranon, and thence, the point of the knife touching the bone, directly downward along the inner side of the posterior aspect of the ulna for one or two inches.

The fascia is then divided in the line of the incision, and the interstice between the triceps on one side and the supinator longus, radial extensor, and anconeus on the other, followed down to the capsule and bone. The capsule is opened, and the humerus denuded on its anterior and posterior faces as far inward as possible, care being taken to maintain the relations of the muscular and ligamentary attachments.

The tendon of the triceps and the periosteum of the ulna

FIG. 52.



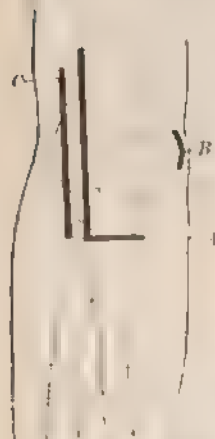
Excision of the elbow joint. A Von Langenbeck. B. Ollier.

¹ *Traité de la Régénération des Os*, p. 740.

are next detached, and in separating the former it is better to begin inside the joint at the free edge of the olecranon.

The denudation of the external condyle and tuberosity of the humerus is then completed, and the external lateral ligament entirely detached, the forearm flexed on its inner side, and the end of the humerus dislocated outward into the wound, thus rendering the difficult dissection of the projecting epitrochlea easier.

FIG. 53.



Removal of the elbow joint. A. Nélaton B. C. Hueter

When this latter has been completed, the periosteum of the humerus is raised circularly to the proper height, and the bone sawn through. The head of the radius is then removed, the denudation of the ulna completed, and the bone sawn through perpendicularly to its axis.

Nélaton's Method. (Fig. 53, A.)

A longitudinal incision is begun on the outer border of the humerus between the triceps and supinator longus, $1\frac{1}{2}$ inches above the end of the olecranon, and carried downward for a distance of 3 inches. A transverse incision cutting through to the bone is next made from the lower end of the first, across the ulna to its inner border.

The triangular flap thus formed, including the periosteum of the ulna, is dissected up, the external lateral and orbicular ligaments divided, and the head of the radius removed. The tendon of the triceps is detached and the denudation of the ulna completed.

The ulna is projected through the incision by bending the forearm toward its inner side, and is sawn off.

The humerus is then easily turned out through the incision, denuded from below upward with the usual precautions, and sawn off at the desired height.

Long Radial Incision (Hueter).¹ (Fig. 53, B and C.)

A preliminary longitudinal incision, half an inch long, is

¹ Deutsche Zeitschrift für Chirurgie, 31 vol., p. 68.

first made directly down upon the tip of the epitrochlea, or rather on its anterior side, so as more surely to avoid the ulnar nerve which lies close behind it, and the muscular attachments and the internal lateral ligament are separated by cutting around this prominence.

The main incision is then made by entering the knife above the point of the external epicondyle and carrying it straight down over it, thus opening the joint and exposing the head of the radius by dividing the external lateral ligament longitudinally and the orbicular ligament transversely. The head of the radius is then removed after sawing through its neck.

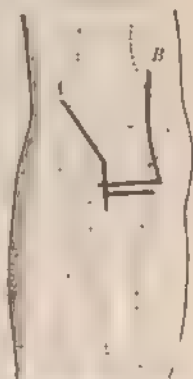
The operator then passes his left forefinger through the wound, first to the anterior surface of the humerus to make the capsule tense, and guide the detachment of it and the periosteum, and then along the posterior surface under the tendon of the triceps with the same object.

It is not necessary to carry this dissection very far toward the inner side, because by dislocating the ulna forcibly inward the end of the humerus can be made to project through the radial incision, and then its denudation can be easily and safely completed, and the bone sawn through.

The end of the olecranon is then brought into the centre of the incision, and the separation of the triceps begun at the upper free edge of the process with vigorous short cuts into the substance of the bone, so that it is, as it were, peeled out of its tendinous envelope. When the proper point is reached the bone is sawn through.

Osteoplastic Method. (Fig. 51) This operation, characterized by primary division of the olecranon and its reunion at the close of the operation, was proposed by Von Bruns, and was at first deemed applicable to old, irreducible, and to fresh compound dislocations. Its use has been extended to operations for foreign bodies

FIG. 51.



Osteoplastic method.

A By external incision.

B Von Mosetig-Moorhof.

in the joint, for ankylosis, and finally to those for fungous arthritis.

The procedure recommended by Von Mosetig-Moorhof begins by a transverse incision running from the lowest point of the external condyle across the olecranon to its inner side, thence upward alongside the olecranon to a point one inch above its tip. The ulnar nerve is then dissected out and drawn aside, and the olecranon divided with saw and chisel in the line of the first part of the incision. The flap is then drawn aside, the humerus cleared and sawn off below the epicondyles, the head of the radius removed, and the olecranon scraped and reunited with a silver suture.

I think this exposure of the ulnar nerve is unnecessary and objectionable, and have modified the operation by using the lower two-thirds of Ollier's incision and making a second transverse one from the lower end of the first across the base of the olecranon, and sawing the latter through in this line, but somewhat obliquely from below upward, into the joint. The joint was then further opened through the lateral incision, the external condyle denuded, and the flap, including the upper part of the olecranon, turned upward and inward. This exposed the joint freely, and the humerus was then readily denuded and sawn off through the epicondyles. The radius was then protruded and sawn through at the neck, the olecranon thoroughly scraped, removing most of the coronoid process, and the capsule dissected out. As the scraping of the olecranon had left its sigmoid cavity much too large, I removed a slice one centimetre thick along the line of its original section to shorten it, and then wired the pieces together. The result was very good, and active extension more powerful than in any other case I have seen.

Bilateral Incisions. Vogt¹ speaks highly of a method by which he accomplishes the same result without division of the olecranon. His incision begins above the external condyle and is carried well below the head of the radius, dividing the orbicular ligament; then he removes the periosteum from the radius and divides it with saw or chisel just above its tuberosity, draws aside the edges of the

wound, and explores the joint. If it is extensively diseased, he makes a second incision on the inner side, beginning above and a little behind the epitrochlea and extending about three inches downward, then with a chisel cuts away the attachments of the extensor and flexor muscles from the condyles, leaving a shell of bone attached to them, draws aside the soft parts, divides the capsule, raises the periosteum from the humerus, and saws off the end of the latter. Then, if necessary, he scrapes away the surface of the olecranon.

Partial Excision Ollier's and Hueter's methods are especially applicable to that form of semiarticular excision in which only the lower end of the humerus is resected. Nélaton's or Von Langenbeck's, or the lower part of Ollier's, can be used for the removal of the ends of the ulna and radius.

EXCISION OF ANCHYLOSED ELBOW.

When there is ankylosis of the joint, Von Langenbeck's incision can be used, and the ulna divided with a chain-saw or chisel after it has been denuded. The detachment of the capsule and periosteum is then proceeded with upward, and the lower end of the humerus, with the attached ends of the bones of the forearm, projected through the wound and sawn off.

Or the osteoplastic or either of the two following methods may be employed :

Excision of Anchylosed Elbow (Ollier). An incision two and a half inches long is first made on the outer and posterior side of the limb and carried through to the bone, its centre being on a level with the tip of the olecranon. A second incision one and a half inches long, involving the skin only, is made on the inner side of the ulnar nerve at the level of the internal border of the humerus. The nerve is found on dividing the fascia, is drawn aside together with the posterior lip of the wound with a blunt hook, and is then entirely out of the way of injury.

The lips of the two wounds are separated, the periosteum detached, a narrow saw passed under the triceps, and the humerus sawn nearly through from behind forward, leaving a thin shell of bone in front, which is then broken. The conditions are now those of a movable joint, and more or less of the lower fragment or of each fragment is removed, according to the condition of the bone. The triceps should be detached before the olecranon is divided.

Excision of Anchylosed Elbow (P. Heron Watson¹) This method is intended only for the removal of the articular end of the humerus, in cases of more or less complete ankylosis following injury. The advantages claimed for it are that it leaves the attachments of the triceps and brachialis anticus undisturbed, and limits the area of the operation almost exclusively to within the capsular ligament, and thereby seems to secure a more speedy healing of the wound. Watson has used it in six cases, in all of which the results were satisfactory.

1. A linear incision is made over the ulnar nerve at the inner side of the olecranon.
2. The nerve is carefully turned over the inner condyle.
3. A probe-pointed bistoury is introduced into the elbow-joint in front of the humerus and then behind that bone, and carried upward so as to divide the upper capsular attachments in front and behind.
4. A pair of bone-forceps are next employed to cut off the entire inner condyle and trochlea of the humerus [from above downward], and then introduced in the opposite direction [from below upward and outward], so as to detach the external condyle and capitellum of the humerus from the shaft.
5. The angular end of the humerus is turned out through the incision and sawn off square.
6. The external condyle and capitellum are removed partly by twisting, partly by dissection, without any division of the skin on the outer side of the arm.

If there is dense osseous union that cannot be overcome by flexion and extension under chloroform, the humerus must be divided through the condyle with bone-pliers, and the operation completed as above.

¹ Edinburgh Med Journ. May 1873 p. 200.

*Operative Reduction of Old Unreduced Backward Dislocation of the Elbow.*¹ The first incision is made on the outer side (Fig. 55), beginning well up on the supinator ridge and passing downward to and across the head of the radius, and then for one or two inches posteriorly in the interval between the radius and ulna. Through this the newly formed bone (Fig. 55, A) on the back of the humerus is exposed and chiseled away, and the outer aspect of the external condyle freed by dividing its fibrous attachments to the radius and ulna until the capitellum is freely exposed. The sides of the upper portion of the wound are then retracted, the olecranon exposed, and the sigmoid cavity cleared of the mass of fibrous tissue which, more or less, fills it and binds it to the back of the humerus.

A second incision is now made on the inner side. It is about four inches long and slightly curved, with its concavity forward, and it passes close behind the internal epicondyle or its site if it has broken off and is displaced. The ulnar nerve is found on dividing the fascia, and is carefully drawn forward over the internal condyle. The fibrous bands between the condyle and olecranon are divided. If the epicondyle has been torn from its position and is attached to the humerus higher up, it must be freed and brought back with its attached internal lateral ligament. The division of the soft parts must be continued until the trochlear surface of the humerus is freely exposed. If the injury is of long standing, and thereby the flexor muscles permanently shortened, they must be separated from the internal condyle before reduction can

FIG. 55.



Incision for the operative treatment of old unreduced dislocation of the elbow.

A. Periosteal bridge and new tissue occupying the posterior surface of the lower extremity of the humerus

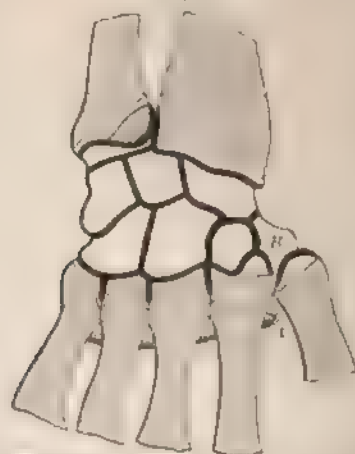
¹ Dr. L. A. Simon, N. Y. Med. Jour., Oct. 21, 1891.

be accomplished. After the wound is closed the arm is dressed at right-angles in an immobilization apparatus.

EXCISION OF THE WRIST.

Posteriorly and laterally the wrist is covered only with skin and tendons, with no arteries or nerves of importance except the radial artery, which winds around the outer side to pass again through the first metacarpal space to the palmar aspect of the hand, and form the deep palmar arch just below the bases of the metacarpal bones. Between the extensor tendons of the thumb and of the forefinger exists a triangular interval, shown in Fig 57, the apex of

FIG. 56.



Excision of the wrist—Lateral. A Deep palmar arch. B Trapezium. C Articular surface of the ulnar. The dotted lines indicate the amount removed in the various operations; the unshaded portions represent those removed when the disease is limited to the carpus.

which is directed upward and lies near the middle of the dorsal aspect of the epiphysis of the radius. Within this space are found only the tendons of the long and short extensores carpi radiales, with their insertions into the second and third metacarpals, and as experience has shown that

these tendons can be detached or divided without prejudice to the subsequent usefulness of the hand, the articulation can be safely approached through this space.

The extensor tendons are lodged in deep grooves upon the surface of the radius, from which it is very difficult to raise them without opening their sheaths, and therefore if it is necessary to take more than a thin slice from the bevelled end of the bone, it should be done with a gouge and as a late step in the operation. In this way it is possible to leave the tendons unhurt, and even unseen.

On the inner side the tendon of the extensor carpi ulnaris covers the ulna, in front of it passes the flexor carpi ulnaris on its way to its insertion into the pisiform bone and the base of the fifth metacarpal. The anterior aspect is occupied by the numerous and important flexor tendons, the median and ulnar nerves, and several arteries or arterial branches of considerable size. Toward the outer side the tendon of the flexor carpi radialis passes through a groove on the surface of the trapezium, to be attached beyond the base of the second metacarpal. An ulnar incision should pass between the flexor and extensor carpi ulnaris at the anterior border of the ulna.

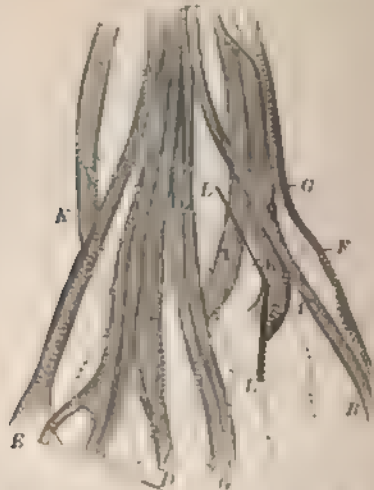
Bilateral Incisions (Lister¹). Figs. 57 and 58, A, B. All adhesions are first broken down by freely moving all the articulations of the hand. The radial incision is made in the situation indicated by the line *L L* in Fig. 57, or Fig 58, A. It commences above at the middle of the dorsal aspect of the radius on a level with the styloid process. Thence it is at first directed toward the inner side of the metacarpophalangeal articulation of the thumb, running parallel to the tendon of the extensor secundi intermedii; on reaching the radial border of the second metacarpal bone it is carried downward longitudinally for half the length of the bone.

The soft parts on the radial side of the incision are next detached from the bones with the knife guarded by the thumb-nail, so as to divide the tendon of the extensor carpi radialis longior at its insertion into the base of the second

¹ *Lancet*, 1865, p. 225, slightly abridged.

metacarpal, and raise it along with that of the extensor brevis, previously cut across, and the extensor secundi internodii, while the radial artery is thrust somewhat outward. The trapezium is then separated from the rest of the carpus by means of cutting-forceps applied in a line

FIG. 57



Extension of the wrist, Lister. A The radial artery. B Extensor secundus internodii pollicis. C Ext. comm. digitorum. D Ext. min. dig. E Ext. pol. int. pol. F Ext. carpi rad. long and brev. G Ext. carpi uln. H Line of median incision.

with the longitudinal part of the incision. The removal of the trapezium is reserved till the rest of the carpus has been taken away. The soft parts on the ulnar side of the incision are now dissected up as far as is convenient, the extensor tendons being relaxed by bending back the hand.

The knife is next entered on the inner side of the arm, two inches above the end of the ulna, immediately anterior to the bone, and is carried downward between it and the flexor carpi ulnaris, and on in a straight line as far as to the middle of the fifth metacarpal bone at its palmar aspect (Fig. 58, B). The dorsal lip of the incision is raised, and the tendon of the extensor carpi ulnaris cut at its insertion

into the fifth metacarpal, and dissected up from its groove in the ulna, care being taken to avoid isolating it from the integuments, and thus endangering its vitality. The extensors of the fingers are then readily separated from the carpus, and the dorsal and internal ligaments divided, but the connections of the tendons with the radius are purposely left undisturbed.

The anterior surface of the ulna is then cleared by cutting toward the bone, so as to avoid the artery and nerve; the articulation of the pisiform is opened, if that has not been already done in making the incision, and the flexor tendons are separated from the carpus. While this is being done the knife is arrested by the process of the unciform bone, which is clipped through at its base with pliers. The knife must not be carried further down the hand than the bases of the metacarpal bones, so as not to injure the deep palmar arch. The anterior ligament of the wrist-joint is divided, after which the junction between the carpus and metacarpus is severed with cutting-pliers, and the carpus extracted through the ulnar incision by seizing it with strong forceps and touching with the knife any ligamentous connections that may remain undivided.

The hand being now forcibly everted the articular ends of the radius and ulna will protrude at the ulnar incision. If they appear sound or only superficially affected, the articular surfaces only are removed. The ulna is divided obliquely with a small saw, so as to take away the cartilage-covered rounded part over which the radius sweeps, while the base of the styloid process is retained. The end of the radius is then cleared sufficiently to allow a thin slicer to be sawn off parallel to the general direction of the inferior articular surface and the articular facet on the ulnar side of the bone is clipped away with bone-forceps. If, on the other hand, the bones prove to be deeply carious, the pliers or gouge must be used with the greatest freedom.

The metacarpal bones are next dealt with on the same principle. If sound, only the articular surfaces are clipped off.

The trapezium is next seized with forceps and dissected out, so as to avoid cutting the tendon of the flexor carpi radialis, which is firmly bound into the groove on its palmar

aspect, the knife being also kept close to the bone elsewhere to preserve the radial artery. The articular end of the first metacarpal is then removed. Lastly, the articular surface of the pisiform is clipped off, the rest of the bone being left if sound. The process of the unicorn is also left if sound. The radial wound may be closed with sutures, but the ulnar one must be kept open for drainage, and the limb must be bound upon a splint in such a manner that while the wrist is firmly fixed passive motion can be given regularly to the fingers.

Radial Incision (Ollier). Fig. 58, *C*. An incision involving only the skin is begun on the outer side of the wrist, an inch below the styloid process of the radius, and



FIG. 58.

Excision of the wrist. *A* Lister's radial incision. *B* Lister's ulnar incision.
C Ollier. *D* Von Langenbeck.

carried upward along the outer border of the bone for a greater or less distance, according to the amount to be removed. A cutaneous branch of the radial nerve is exposed and drawn aside, the fascia divided, and the extensor tendons of the thumb recognized. These tendons are a guide which is easily found. They are superficial, and contained in a separate groove. On opening the sheath and drawing them aside, the insertion of the supinator longus is exposed,

on the outer side of which, and parallel to the tendon, the periosteum of the radius must then be divided.

Using a straight, sharp elevator, the surgeon next detaches the tendon of the supinator, preserving its relations with the periosteum, and then denudes the lower end of the radius inward, removing periosteum and capsule. Then, bending the hand forcibly toward its inner side, he separates the remaining fibrous attachments and dislocates the lower end of the radius outward. The ulna can be protruded through the same wound and denuded from below upward, but it is better to make a longitudinal incision on the inner side for this purpose.

The ends of the radius and ulna are then sawn off, and through the gap thus left the carpal bones are successively removed with gouge and forceps.

Dorso-radial Incision (Von Langenbeck). Fig. 58, *D*. The hand is bent toward the inner side, and an incision is begun at the ulnar border of the second metacarpal bone near its middle and carried upward four inches, crossing the ulnar edge of the tendon of the extensor carpi radialis brevis, where it is inserted into the base of the third metacarpal bone, and splitting the dorsal ligament of the wrist exactly between the tendons of the extensor secundi inter-nodii and extensor of the forefinger. This incision should be carried down to the bone, and the soft parts detached on the radial side with an elevator; the tendons, where they lie in the grooves, are raised bodily with the periosteum, and their sheaths are not opened.

The hand is flexed so as to make the first row of carpal bones present in the wound; the scaphoid is separated from the trapezium and taken out, and followed in turn by the semilunar and cuneiform, the interosseous ligament being cut and the bones pried out with a small elevator. The trapezium and pisiform are left if possible.

To take out the second row, the operator steadies the round articular end of the os magnum with the fingers of his left hand, and, while an assistant abducts the thumb, he divides with a knife the connection between the trapezium and trapezoid, passes the knife into the carpo-metacarpal joint, and cuts the ligaments on the dorsal side of the ends

of the metacarpal bones while an aid flexes them. In this way the trapezoid, magnum, and unciform can be brought out together.

The lateral ligaments are then carefully separated from the radius and ulna, the bones protruded and sawn through.

EXCISION OF THE HIP-JOINT.

In this joint, as in the shoulder, the disease is often confined to the head of the bone, and under such circumstances partial excision should be performed. When the acetabulum is diseased the loose pieces must be picked out and the gouge applied to the roughened surface. The line of section of the femur should pass below the great trochanter, however limited the disease may be, for if this process is left it is liable to protrude through the wound and obstruct the escape of the secretions. If the disease extends beyond this point, additional slices must be removed, or the gouge used until healthy bone is reached.

The anatomical disposition of the parts is such that the joint is best approached from the outer and posterior aspect, the incision passing over the top of the great trochanter. Different surgeons have inclined the upper part of the incision forward and backward at various angles, or have dissected up a triangular flap, its apex directed sometimes upward, sometimes downward.

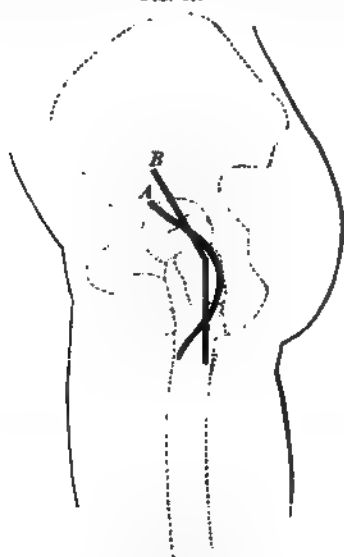
Sayer's Method. (Fig. 59, A.) Enter the point of the knife midway between the anterior superior spine of the ilium and the top of the great trochanter, and drive it down to the bone; then, keeping it firmly in contact with the bone, draw it in a curved line to the top of the trochanter, midway between its centre and posterior border, thence forward and inward, making the whole length of the incision from four to eight inches, according to the size of the thigh. Make sure that the periosteum is divided throughout.

Then, drawing aside the soft parts, divide the periosteum transversely just opposite to, or a little above, the lesser trochanter, carrying the division as far as possible around the bone. Beginning at the angle formed by the two incisions, raise the periosteum on each side, together with its

membranous attachment, as far as the digital fossa. Then, substituting a knife for the periosteal elevator, divide the insertions of the muscles at this point, keeping close to the bone, and afterward separate the remaining periosteum as far as can be done without tearing it. Then adduct the leg slightly and raise the head of the femur gently out of the acetabulum; this will detach the last of the periosteum, and allow the finger to be passed around the bone as a guide for the saw, which should be applied just above the lesser trochanter.

If the bone cannot be readily dislocated, saw it through first, and then remove the head with the forceps or elevator.

FIG. 59.



Excision of the hip. A. Sayre. B. Ollier.

If the acetabulum is perforated, the edges must be chipped off very carefully down to the point at which the periosteum on the pelvic side is still adherent.

Ollier's Method. (Fig. 59, B.) Ollier makes a somewhat similar incision. It begins four finger-breadths below

the crest of the ilium, and the same distance behind the anterior superior spine, runs downward to the most prominent part of the great trochanter, and thence directly down the shaft of the femur. Its upper part should involve the skin and fascia only. The posterior lip, including the gluteus maximus, is drawn back, exposing the gluteus medius, the fibres of which are then separated without cutting them. This permits the attachments of the gluteus medius to be preserved, and the gluteus minimus can be exposed by drawing apart the edges of the opening made in the other, and then divided in the same manner or drawn forward with a blunt hook.

The capsule is split from the edge of the cotyloid cavity to the digital fossa, and detached together with the tendinous insertions. The head of the femur is dislocated backward, the ligamentum teres divided, and the denudation continued downward to the lesser trochanter. The bone is then protruded and sawn off with a chain or common saw.

Langenbeck's Method. The thigh is flexed at an angle of 45° and rotated inward. The knife is entered just below a point opposite the junction of the upper and middle thirds of a line joining the posterior superior spine of the ilium and great trochanter; in other words, just below the most anterior portion of the great sciatic notch. Thence following the long axis of the flexed femur it is carried in a straight line over the outer surface of the great trochanter, making an incision which penetrates to the bone throughout and is about four or five inches long. The glutei are thus divided in the direction of their fibres, the margins of the wound retracted, and the capsule opened by a longitudinal aided by a transverse incision close to the edge of the acetabulum. After severing the attachments of the muscles to the great trochanter the head of the bone is dislocated backward and brought out of the wound and sawed off.

Anterior Incision. Roser recommends, in order to preserve the trochanter, an anterior incision in the line of the neck of the femur, beginning just outside the crural nerve, and dividing the iliacus, rectus, sartorius, and tensor vaginæ

femoris. The capsule is divided in the same line, the head turned forward into the wound by rotating the thigh outward, and sawn off.

Lücke and Schede have modified this by making the incision vertical instead of transverse, beginning outside the crural nerve a little below and to the inner side of the anterior superior spine of the ilium, and running directly downward. The inner borders of the sartorius and rectus are exposed and drawn outward, and then the outer border of the psoas-iliacus exposed and drawn inward. Then the thigh is flexed, abducted, and rotated outward, and the capsule divided.

A similar incision and approach to the joint may be used in the operative reduction of old dorsal dislocation.

Barker¹ employs the following method: The incision begins on the front of the thigh half an inch below the anterior superior spine of the ilium, and extends about three inches downward and a little inward. The muscles are recognized as the successive layers of tissue are divided. The tensor vaginæ femoris and glutei are drawn to the outer side, the sartorius and rectus to the inner, and the neck of the femur exposed. The external cutaneous nerve will be encountered in the upper angle of the incision; lower down and deeper are the external circumflex vessels. The deeper part of the incision need not be made as long as the more superficial. Any abscess which may be opened should be thoroughly washed out before proceeding further.

The neck of the femur is divided with a narrow saw in the direction of the external wound, and the diseased head removed with sequestrum-forceps. The acetabulum and all other parts of the joint-cavity are explored by the forefinger, and any diseased tissue cut or scraped away. Mr. Barker fills the wound with iodoform emulsion and generally closes it up tight. The patient is placed upon a double Thomas splint for several weeks.

Arthroectomy of the Hip-joint by Chiselling through the Great Trochanter (Tiling). An incision three or four

inches long is made along the anterior border of the great trochanter, which is chiseled off and laid back. The capsule of the joint is divided longitudinally, the periosteum elevated from the neck of the femur, and the head of the femur dislocated. Then the lesser trochanter is also chiseled off and the acetabulum cavity is freely accessible.

ANCHYLOSIS OF THE HIP-JOINT.¹

When the ankylosis is not associated with the loss of a great part of the head and neck of the femur—that is, when it follows inflammation of the joint due to rheumatism, pyemia, traumatism, or chronic disease that has been arrested at an early stage—Mr. Adams's operation of subcutaneous division of the neck of the femur may be applicable, but usually division below one or both of the trochanters, or excision of the head and neck, is to be preferred.

FIG. 60.



Subcutaneous division of the neck of the femur.

Division below the lesser trochanter is only undertaken to remedy a faulty position of the limb, for there can be no question of establishing a new joint below the insertion of

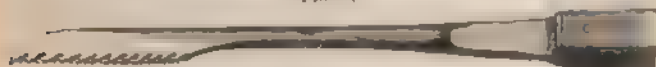
¹ This subject, which properly belongs to orthopedics, is placed here on account of its intimate relations with excision of the joint.

the psoas and iliacus. It is doubtful also if a permanently movable joint can be obtained by division at a higher point; it certainly cannot unless a portion of the bone is removed, and probably not even then, for the tendency of the cut ends to unite after a time is very great.

Subcutaneous Division of the Neck of the Femur (Adams¹). The only special instrument needed is a saw somewhat resembling a tenotomy knife, the cutting part being one and a half inches long and three-eighths of an inch wide, and the shank about two and a half inches long. (Fig. 61.)

A tenotomy knife is entered a little above the top of the great trochanter and pushed straight into the neck of the femur, dividing the muscles and opening the capsule freely. The soft parts being fixed by the thumb and fingers of the left hand, the knife is withdrawn and the saw passed promptly down to the bone through the track made by it.

FIG. 61



Adams's saw for subcutaneous division of the neck of the femur

The bone is then sawn through from before backward, so that the line of section shall be at right angles to the long axis of the neck, care being taken to avoid cutting obliquely through the neck, or in a direction parallel with the shaft of the bone.

Subtrochanteric Osteotomy (Gant's Operation²). An incision is made from one to two inches long on the outer aspect of the thigh an inch to an inch and a half below the great trochanter, according to the size of the patient. It should expose the external surface of the femur just below the site of the lesser trochanter. The blade of the osteotome is introduced through this incision, and the bone divided just below the trochanter minor. After each stroke of the mallet the chisel is loosened and its direction slightly changed

¹ An operation for bony ankylosis of the hip joint with reposition of the limb by subcutaneous division of the neck of the femur. *Lancet*, 1881. Vol. 1, p. 110. Reprinted from the *British Medical Journal* of December 1, 1880.

² Gant's "Science and Practice of Surgery," 1886.

to cut forward or backward. The bone should not be cut entirely through, but when it seems evident that only a thin shell is left it should be carefully fractured. The after-treatment consists in simple extension.

The operations of Adams and Gant are the ones most generally employed for the correction of deformity following ankylosis at the hip in a faulty position. Adams's method is, of course, only applicable to those cases in which the femur still possesses a neck, and inasmuch as the disease which most frequently calls for this kind of interference—namely tuberculosis—generally causes more or less destruction of the head and neck of the femur, the operation of Gant, or subtrochanteric osteotomy, has a wider use.

Excision. Posterior incision as above described, with such modifications as may be made necessary by dislocation; division of the neck with the saw, if possible; otherwise with the chisel; then removal of the head, or what remains of it, by chiselling.

The upper end of the bone is then lodged in the acetabulum, after subcutaneous division of such muscles and soft parts as interfere, and removal of the upper part of the trochanter, if necessary. Extension by weight and pulley must be kept up for a long time.

EXCISION OF THE KNEE-JOINT.

This should always be complete to this extent, that a slice should be taken from each bone; but it is not always necessary to remove the entire articular surface of the femur. In children the amount removed should be as small as is consistent with removal of all that is diseased. The patella may be dissected out and removed entire, or the diseased portions extirpated with the gouge or rongeur; or it may be sawn through parallel with its articular surface. As a general thing the latter method is preferable, unless the bone is so extensively affected that the preservation of even its anterior surface is incompatible with a thorough removal of all the disease.

As ankylosis should always be aimed at, the incision

may cross the front of the joint and divide the ligamentum patellæ or the patella. Some surgeons provide for drainage by making a dependent opening in the popliteal space, but this seems to be unnecessary.

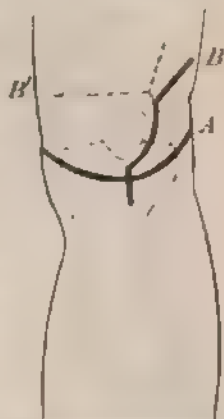
Semilunar Incision. (Fig. 62, A.) The knife is entered on one side of the limb at the posterior part of the condyle, and carried across midway between the patella and the tuberosity of the tibia to a corresponding point upon the other side. This incision should extend down to the bone throughout, dividing the ligamentum patellæ. The flap is reflected, the crucial ligaments divided close to their attachment to the tibia, the lateral ligaments divided, the end of the femur cleared as far as may be necessary, with especial care for the safety of the popliteal vessels, protruded through the wound, and sawn off at the point indicated in Figs. 63 and 64. The line of section must be parallel to the line of the articulation, not at a right-angle to the axis of the shaft, for that is directed inward and downward. If necessary, additional slices of the bone are removed, or the gouge is used. All the articular cartilages should be removed.

The end of the tibia is next projected, cleaned, and sawn off about half an inch below its upper surface.

In sawing the bones it is best not to make a complete section with the saw, but to stop a little short of the posterior surface and complete the separation by fracturing what is left.

Finally, the patella is taken out, and diseased portions of the synovial membrane scraped or clipped off, or the articular surface of the patella may be removed with the saw or rongeur, and the anterior bony shell which is attached to the quadriceps tendon left. The operation is

FIG. 62



Excision of the knee-joint.

A. semilunar incision.

B. collar incision.

completed by suturing in position the divided ligamentum patellæ.

FIG. 63.



FIG. 64



sections to show the position of the epiphyseal cartilage at the knee and the points at which the section ought to be made in extension

Transverse Incision. The incision should cross the patella at or just below its centre and extend beyond the centre

of the condyle on each side ; at each end should be made a longitudinal incision extending two inches above and one inch below the transverse one ; the patella is then divided at its centre transversely, and the fragments turned up and down, and the joint thus opened and cleaned.

At the close of the operation the patella is replaced and united with sutures ; the patella may be entirely removed ; or, in the first place, after exposing the bone, the patella may be dissected out, and at the close of the operation the quadriceps tendon reunited.

Arthrectomy, or Extirpation of the Knee-joint. This term has been given to the systematic removal of the synovial membrane and any small portions of the rest of the articulation which may on inspection be found to be diseased. The above-described semilunar incision is employed, and the anterior flap containing the patella reflected. After removing all pulpy and degenerated tissue in the suberural pouch the lateral and crucial ligaments, if necessary, are cut, although the latter should be spared whenever possible. The joint is thus thoroughly exposed, and all the diseased parts in its interior excised, together with the semilunar cartilages. Foci of inflammation in the bone must be removed with the sharp spoon or rongeur. The field of operation is then flushed out with some antiseptic solution, the ligamentum patellæ sutured in position, and the cutaneous wound loosely united. Whenever it is deemed desirable drainage-tubes may be inserted in the posterior angles of the incision. Immobilization of the leg in extension must be maintained for several weeks.

EXCISION OF THE ANKLE-JOINT.

The results of excision of the ankle-joint have been, on the whole, so unfavorable that the English and German surgeons are inclined to abandon it entirely. When the operation has been undertaken on account of caries, the disease has usually returned in the tarsal bones, and rendered secondary amputation necessary. When, on the other hand, it has been performed on account of injury, the mortality has been great, secondary amputation has been fre-

quently required, and the position of the foot in the case that recovered has usually been faulty.

The results of conservative expectant treatment have been no better, and, in part, for the same reasons. In correspondence, as has been pointed out, with the late consolidation of the epiphysis, inflammation of this extremity is likely to be severe, and its destructive results extensive. the reproduction of bone is also very abundant and leads almost necessarily to ankylosis, so that, unless great attention is given to maintaining the foot in a proper position during the whole period of treatment, it will unite at a faulty angle, with inversion or eversion of the sole, and inability to support the weight of the body.

As ankylosis is to be expected, the rule in excision is to remove the smallest possible amount of bone, and to make

FIG. 65.



Excision of ankle

partial instead of complete excision when the disease does not extend to the whole joint. The retention of one or the other malleolus is a great help in preventing shortening, and in the use of a plaster splint. The interosseous membrane between the tibia and fibula must be preserved carefully. It not only has a great tendency to ossify, but also seems to favor the reproduction of bone.

Operation (total excision). An incision involving only the skin is begun two inches above the external malleolus and a little behind the middle of the fibula, carried directly down to the end of the bone, and thence forward and slightly upward toward the malleolus for an inch (Fig 65). The periosteum covering the fibula is divided throughout and

dissected up from the bone with the attachment of the lateral ligaments, especial care being taken not to open the sheath of the peroneal muscles at the posterior border of the malleolus, and to remove all the thick periosteum and the inter-

seous membrane on the inner side. If necessary, a transverse liberating incision may be made through the periosteum at the upper end of the cut. The bone is then divided with a keyhole saw or chisel, the upper end of the lower fragment drawn out of the wound to expose and facilitate the separation of the remaining attachments, and the piece removed.

The soft parts are then held out of the way with retractors, and the upper articular surface of the astragalus sawn off with the keyhole saw, but not removed.

The foot is next turned upon its outer side, and a longitudinal incision two or three inches long made along the side of the tibia, ending half an inch below the tip of the malleolus, where it is then crossed by a short horizontal one involving the skin only. The periosteum of the tibia is divided in the line of the incision and transversely at its upper end, and dissected off, the bone sawn through, and the piece removed. Langenbeck makes the line of section oblique downward and outward, because it is easier to do so, but most surgeons prefer to have it transverse. The upper part of the astragalus, which has been previously sawn off, is then removed through the same incision.

The gouge is used to scrape away any diseased parts found on the cut surface of the astragalus, or the bone may be seized with strong forceps and dissected out entirely.

If the injury has affected the astragalus only (as in some gunshot wounds), its splinters are best removed through a longitudinal incision upon the dorsum of the foot between the extensor tendons of the first and second toes.

Vogt's Method, by Removal of the Astragalus. A serious objection to the use of the preceding operation in cases of tuberculous disease lies in its insufficient exposure of the interior of the joint to view, and it has been proposed by Hueter to return to the old method of an anterior transverse incision with division of all the extensor tendons, and by Busch to open the joint by cutting across the sole and sawing through the calcaneum. Vogt,¹ however, has pro-

¹ *Centralblatt für Chirurgie*, 1883, p. 229.

posed and employed another method, which avoids the extensive division of the soft part and which enables the surgeon to explore the joints thoroughly, and, if necessary, to excise the synovial membrane. It consists in primary methodical extirpation of the astragalus without resection of the malleolus.

Operation. A longitudinal incision on the outer side of the extensor tendons, three or four inches long, beginning above between the tibia and fibula, and ending below at the line of the calcaneo-cuboid joint; after division of the fascia the tendons are raised in their sheaths, carefully separated from the underlying parts, and strongly retracted to the inner side. The extensor brevis is then cut, the outer side of the incision retracted, the capsule split longitudinally to its full extent and separated on both sides from the bone with knife and elevator, the head and neck of the astragalus cleared, and the astragalo-scapoid ligament divided.

A second incision is made from a point somewhat below the centre of the first backward below the external malleolus, dividing everything down to the astragalus, but sparing the peroneal tendons. The foot is then supinated the anterior ligaments cut away from the external malleolus, and the strong interosseous ligament divided by thrusting a small strong knife into the groove between the astragalus and calcaneum. The head of the astragalus is then drawn forcibly outward with a stout hook, while the foot is supinated, the deep portion of the internal lateral ligament cut by passing a knife between the malleolus and the astragalus, the latter drawn forward into the incision, and its posterior attachments cut.

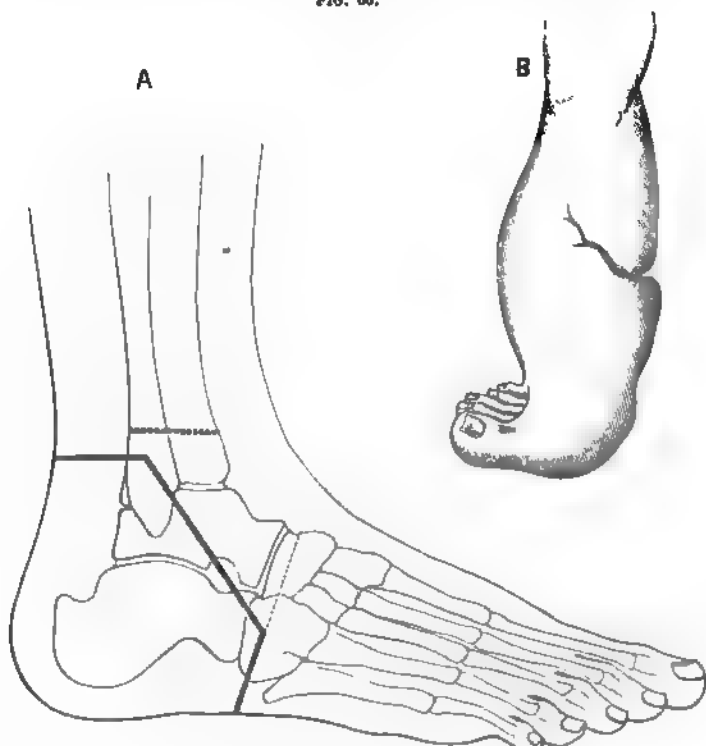
The remainder of the operation will vary with the extent and character of the disease. All the adjoining bones are freely exposed to inspection, and can be scraped, gouged out, or sawn off.

I have found the execution of this operation easy, even when the capsule was much thickened by disease, and its exposure of the interior of the joint is very satisfactory.

OSTEOPLASTIC EXCISION OF THE FOOT (HEEL AND ANKLE) (MIKULICZ).

This ingenious operation, the results of which have proved very satisfactory, was introduced by Mikulicz in 1881.¹ It is specially applicable to cases in which the integument about the heel has been extensively destroyed.

FIG. 66.



Osteoplastic excision of the foot. (Mikulicz.)

Operation. (Fig. 66.) Abdominal decubitus. An incision beginning a little in front of the tubercle of the

¹ Archiv für klinische Chirurgie, vol. xxvi., p. 181.

scaphoid is carried directly across the sole of the foot to a point just behind the base of the fifth metatarsal bone. From each end of this one another incision is carried backward and upward to the base of the corresponding malleolus, and the upper ends of the last two incisions are then united by a fourth which passes horizontally across and divides the tendo Achillis. In all the incisions the knife is made to touch the bone throughout.

The lateral ligaments of the ankle are next divided, the joint opened from behind, and the calcaneum and astragalus carefully dissected from the tissues in front of the incisions and removed by disarticulating at the mediotarsal joint.

Finally, the malleoli and lower articular surface of the tibia and the posterior portion of the cuboid and scaphoid are sawn off, as shown by the dotted lines in the figure, the cut being made from behind forward.

FIG. 67.



External incision for the operative treatment of old unreduced Pott's fracture. The astragalus is displaced backward. Its articular surface is partially occupied by the new cuboid tissue developed under the periosteal bridge at the lower end of the posterior surface of the tibia.

The cut surfaces of bone are then brought into apposition and fastened together with nails or sutures, and the wound closed. Fig. 66, B, represents the result.

Operative Treatment of Old Unreducible Pott's Fracture.¹

The Eschmarch rubber bandage or tourniquet is applied and tied below the knee. An incision is begun on the outer side three inches above the ankle, and carried down along the front of the fibula to the malleolus, and thence in a curve forward toward the fifth metatarsal (Fig. 67). The seat of the fibular fracture is exposed, and the lower fragment again separated with the chisel.

A second longitudinal incision about five inches long is made over the inner side, extending past the malleolus to the tubercle of the scaphoid (Fig. 68). Through it the

FIG. 68.



Internal incision for the operative treatment of old unreduced Pott's fracture.
The astragalus is represented as displaced backward.

mass of new tissue that has formed between the astragalus and the internal malleolus is removed or the broken and displaced malleolus is mobilized.

By now working through both incisions the back of the lower end of the tibia can be freed of such cicatricial tissue or new bone as has formed there, and the foot so mobilized that it can be brought back to its proper place. The periosteum and ligaments are sutured in position with catgut, the wound loosely closed without drainage, and after applying a bulky dressing the tourniquet is removed.

¹ Stimson: N. Y. Medical Journal, June 25, 1892.

EXCISION OF THE BONES AND SMALLER ARTICULATIONS.

EXCISION OF THE SUPERIOR MAXILLA.

This operation may be required on account of malignant tumors of the bone or antrum, or of suppurative osteitis and necrosis, or to give access to the base of implantation of a naso-pharyngeal polyp. In the first case the periosteum should not be retained; in the second its separation from the bone is in great part accomplished by the inflammatory process; in the third it should be carefully retained so as to diminish the subsequent deformity.

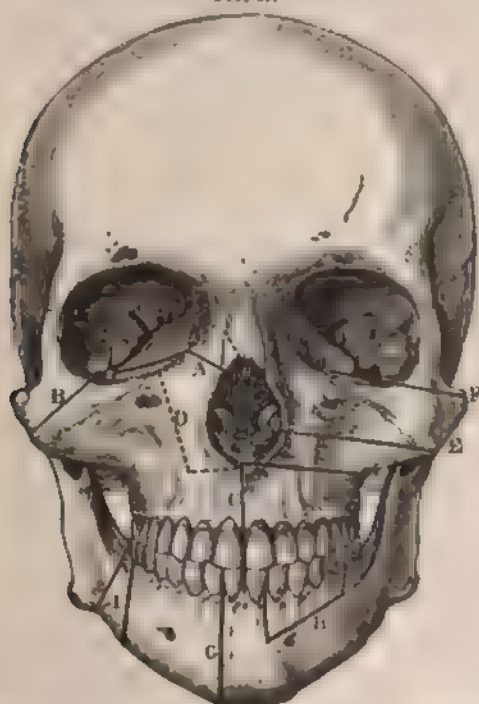
In total excision the bony connections that require to be divided are: (1) The one with the malar bone below the outer angle of the orbit. (2) That with the opposite bone along the centre of the hard palate. (3) Those formed by the nasal process near the inner angle of the orbit; and (4) that with the palate bone and pterygoid process of the sphenoid. (Fig. 69.) The first may be divided by nicking the anterior surface of the bone with a saw, and completing the division with cutting forceps, or with chisel and mallet, or by passing a chain-saw around it, through the spheno-maxillary fissure in the orbit and zygomatic fossa. The second is divided, after having drawn one or both incisor teeth, by means of a saw passed into the nostril, or with cutting forceps with long narrow blades, or a chisel. The third is easily divided with forceps or a chisel, and the fourth by twisting the bone downward after all the other connections have been severed.

The periosteum, covering the floor of the orbit, is thick and easily detached; that on the hard palate is thick and difficult of removal, on account of the irregularities of the surface. There is but little danger of injury to the internal maxillary artery, and it is seldom necessary to apply more than one or two ligatures to its divided branches. Oozing is arrested by packing with aseptic or iodoform gauze.

In partial excision the orbital plate is left, the line of division of the bone passing through the anterior wall of the antrum from the nostril to the lower corner of the

union with the malar bone. The remaining attachments are then broken as before. There are also other varieties of partial excision for the removal of naso-pharyngeal polypi; removal of the nasal process with the nasal bone; removal of part of the hard palate (Nélaton); and temporary removal of different portions, preserving the connection with the soft parts, and replacing them after the polyp has been removed.

FIG. 69.



Lines of bony division in the different operations on the superior and inferior maxilla.

A, B, C Total excision of the superior maxilla. D Boeckel's operation. E C. Guerin's operation. F F. Langenbeck's operation for naso-pharyngeal polypus. G Excision of inferior maxilla. H Removal of a portion of the alveolar process for epulis. I. Esmarch's operation for ankylosis of inferior maxilla.

The incisions that have been proposed may be classed as (1) external and (2) median; the former extending from

the angle of the mouth upward and outward to the malar bone; the latter passing from or near the middle of the lip up toward the inner angle of the eye. The former are open to the objections that they divide the branches of the facial nerve, endanger Steno's duct, and leave a conspicuous scar. The preference is now generally accorded to the median incisions. These follow the outline of the side of the nose more or less closely, and some of them are supplemented by a transverse incision, passing a quarter of an inch below the lower margin of the orbit. For partial excision Guérin recommends an incision passing from the side of the wing of the nose along the naso-labial fold to the angle of the mouth (Figs. 69, 70, 71).

In order to avoid the swallowing of blood, it is well not to carry the incision through the lip or divide the gingivolabial fold until after the anterior face of the bone has been denuded as far as possible.

It is possible to remove the superior maxilla through the mouth without making any cutaneous incisions, but it is a very difficult and painful operation, and the hemorrhage is most embarrassing. Larghi has removed both bones through the mouth, upon the cadaver, and says it is easier to remove both together than one alone in this way.

In simultaneous excision of both superior maxillæ, the same incisions may be made on both sides as for the removal of only one, or Dieffenbach's median incision may be made along the ridge of the nose and the middle of the upper lip.

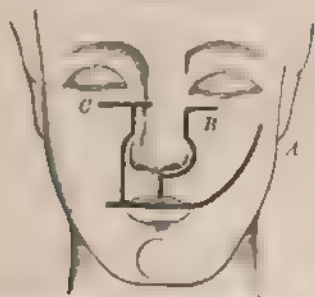
Operation by a Median Incision. (Fig. 70, B) The usual method of operation is as follows: The incision is begun half an inch below the inner canthus of the eye. It is carried down the line of the junction of the nose with the face and along the groove which limits the ala nasi, thence horizontally to the septum, and so down to the free border of the lip in the median line.

This incision may be supplemented, if necessary, by one joining it at the inner canthus and following the edge of the orbit outward.

The cartilage of the nose is separated from the bone and reflected inward with the small internal flap, the edge of

the orbit cleared, and the external flap dissected outward as far as to the malar bone above and the tuberosity of the maxilla below, if possible, the infraorbital nerve being divided at its point of emergence from the foramen.

FIG. 70.



Excision of superior maxilla. A. External incision. B. Notaton's incision.
C. Boeckel's incision

The periosteum of the floor of the orbit is then detached with the handle of the knife, as far as the speno-maxillary fissure, the malar process or bone cut through with the saw or forceps, and the thin plate of bone forming the floor of the orbit divided with the knife obliquely inward and forward from the anterior end of the speno-maxillary fissure. The superior maxillary nerve, which can be readily distinguished through the bone, should also be divided as far back as possible. Finally, the nasal process is divided.

The incision is then carried through the lip, and the detachment of the external soft parts completed.

The mucous membrane of the roof of the mouth is divided transversely on a line with the last molar tooth, and longitudinally in the median line. An incisor tooth is then drawn, and the hard palate divided with saw or forceps close to the septum.

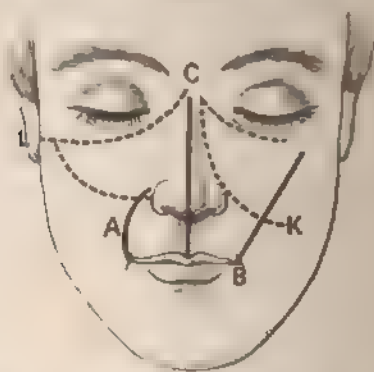
If the mucous membrane of the roof of the mouth is not diseased it may be retained. Instead of the incisions through it just mentioned, one is made along the inner border of the alveolar process, its edge raised, and the membranes detached inward and backward to the median line. After the removal of the bone it unites with the cheek, closes in the

mouth as before, and may become strengthened by a deposit of bone.

Finally, the bone is grasped with strong forceps, twisted downward to break its posterior connections, and removed, generally bringing with it part of the palate bone, the hamular process of the pterygoid, and some attached muscular fibres.

Subperiosteal Excision (Ollier). This method can be employed with the median incision above mentioned, but Ollier prefers an external one (Fig. 71, B).

FIG. 71.



A. Guerin's incision for partial removal of superior maxilla. B. Ollier's incision for subperiosteal excision of superior maxilla. C. Boeckner's - palatal incision for removal of both bones. D. Langenbeck's incision for naso-pharyngeal polypus. E. Boeckner's incision for naso-pharyngeal polypus.

1. *Cutaneous Incision.* An incision is made from the middle of the malar bone to a point on the upper lip one-third of an inch from the angle of the mouth. If necessary, a second incision must be made at the middle of the lip and carried upward around the nostril.

2. *Incision of Mucous Membrane.* The incision is begun on the outer surface at the interval between the second incisor and the canine tooth (he does not remove the intermaxillary bone, that which supports the incisor teeth) close to the edge of the gum, carried back around the last molar,

then forward on the inside to a point corresponding to that at which it was begun, and thence obliquely backward to the median line. A short incision through the periosteum is next made from the anterior external extremity of the former upward and inward to a point a quarter of an inch external to the anterior nasal spine.

3. *Separation of the Periosteum.* The periosteum of the anterior surface is then detached with an elevator, care being taken, however, to divide the infraorbital nerve with a knife at its point of emergence, and the denudation is carried along the floor of the orbit. Unless it is necessary to remove the nasal process of the maxilla, the lachrymal sac and duct can be left uninjured and adherent to the periosteum.

The periosteum of the roof of the mouth is then separated from without inward as far as the median line.

4. *Section of the Bone.* The nasal and malar processes are divided with forceps, chisel, or chain-saw, as before described, the canine tooth drawn, the edge of the chisel inserted in the gap left by it, and pressed gently backward and inward to the median line, thence directly backward along the suture.

The bone is then twisted out, the palatal sutured to the external periosteum, and the wound closed.

Excision of the Portion of the Superior Maxilla Lying Below the Infraorbital Foramen (Guérin's Operation). (Figs. 69, E C, 71, A.) An incision, slightly convex externally, is made from the ala of the nose to the angle of the mouth, following the crease usually present in the features at this situation. The alveolar mucous membrane is divided at the point of reflection on to the cheek from the level of the last molar tooth to the middle line anteriorly. The soft parts are dissected up and the nostril opened in front. A narrow saw is passed through the nares and the maxilla sawn horizontally outward. The saw cut passes below the infraorbital canal well above the teeth and through the malar process and maxillary tuberosity; or the bone may be chiselled through on this line. The soft palate is detached from the hard by a transverse incision at the last molar tooth. A middle incisor tooth is next removed and

the hard palate divided in the median line with a saw, chisel, or forceps introduced through the nostril. The detached piece of bone is loosened with a periosteal elevator and wrenched out.

This operation may be performed subperiosteally (usually for naso-pharyngeal polypus), either by the above-described or by a median incision. The muco-periosteum is divided horizontally along the free margin of the inner and outer sides of the alveolar process on the affected side, from the anterior nasal spine around behind the last molar tooth, and elevated to the middle line of the hard palate and to its posterior border, and upward to near the intraorbital foramen on the outer surface of the superior maxilla. The lower half of the latter is next removed as indicated above, and at the close of the operation the mucous membrane is united as far as possible by sutures, thus shutting off the nasal from the oral cavity.

This operation affords an excellent view of the naso-pharynx.

Removal of the Superior Maxilla Above the Alveolar Process (Bérard's Operation). The median incision is used from below the inner canthus of the eye, following the junction of the nose and face through the centre of the upper lip (Fig. 70, B). The soft parts on the affected side are raised as for total extirpation of the maxilla, and the periosteum of the floor of the orbit is detached as far as the spheno-maxillary fissure. The malar process is divided, and then the orbital plate inward and forward from the anterior end of the spheno-maxillary fissure. The superior maxillary nerve is cut as far back as possible, and, finally, the nasal process.

A horizontal saw-cut is then made outward from the nose above the alveolar process. Any adherent structures between the outer extremity of this cut and that through the malar process are freed with the knife or periosteal elevator, and the piece of bone thus mapped out is pried or wrenched away. The sound alveolar process is left *in situ*.

SIMULTANEOUS EXCISION OF BOTH SUPERIOR MAXILLÆ.

An incision may be made from each angle of the mouth to the malar bone and the broad flap reflected toward the forehead, or Dieffenbach's incision made along the ridge of the nose (Fig. 71, C), with or without a transverse one passing across it and below the margin of each orbit.

The bones are removed together, not separately. The malar processes or bones are divided in the usual manner, the nasal processes divided with a chain-saw passed from one orbit to the other through the lachrymal bones, and the vomer separated with cutting forceps. The periosteum of the hard palate is separated from the gums by a semicircular incision and dissected back, the posterior connections broken, and the bone removed by twisting it downward and forward.

PARTIAL AND TEMPORARY EXCISION OF THE SUPERIOR MAXILLA TO FACILITATE THE REMOVAL OF NASO-PHARYNGEAL POLYPS.

Resection of Posterior Portion of Hard Palate (Nélaton). The soft palate is first divided from before backward along the median line, and the incision prolonged forward through the periosteum of the hard palate as far as may be judged necessary. A transverse incision is next made on one side from the anterior extremity of the first toward the teeth, and the flap, including half the soft palate, dissected off the bone from the median line outward. The mucous membrane on the floor of the corresponding nostril is then divided close to the septum, the bone perforated at the anterior corners of the denuded surface, and the separation of the quadrilateral piece accomplished with cutting forceps.

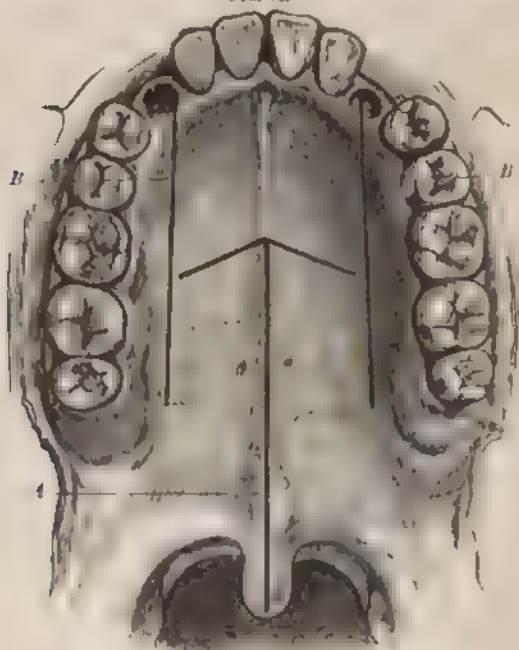
After removal of the polyp the soft parts are replaced and stitched together. The bone is sometimes reproduced.

A little larger opening may be obtained by making the transverse incision extend from one side of the hard palate to the other, and then chiselling away the included bone—in other words, nearly the whole of the bony floor of the

nasal cavity (Fig. 72, *A*). At the close of the operation staphylorrhaphy is performed.

Osteoplastic Resection of the Anterior Portion of the Palate (Chalot, Fig. 72, *B*). The upper lip is everted and the mucous membrane cut in the line of its reflection from the

FIG. 72.



Resection of hard palate to expose nasal fossa.

A Newton's operation.

B Chalot's operation.

bicuspid teeth of one side to a corresponding point on the other—the nasal fossa is thus entered, the canine teeth are extracted, and the alveolus and hard palate divided on each side by the chisel and knife. The line of section runs through the canine sockets and passes back through the hard palate close to its lateral margins as far as its posterior

border. The vomer is then separated, and the quadrilateral piece of bone thus marked out is turned down, the unsevered attachments of the soft palate serving as a hinge. At the close of the operation it is replaced and sutured in position.

Resection of the Upper Portion, leaving the Hard Palate and Alveolar Process (Von Langenbeck). The following is somewhat abridged from the description in the *Deutsche Klinik*, 1861, page 283 :

An incision convex downward from the ala of the nose to the malar bone, and along the zygoma backward. A second incision from the nasal process of the frontal along the lower border of the orbit, meeting the first at the middle of the malar bone (Fig. 71, *L*).

The knife penetrates to the bone throughout. The periosteum and overlying soft parts are only separated sufficiently to permit the use of a saw or chisel along the lines thus indicated. But the periosteum on the upper side of the second incision is detached from the floor of the orbit as far back as the spheno maxillary fissure.

Next the masseter is separated from the exposed portion of the malar bone, and a pointed elevator is passed horizontally below the zygomatic arch and through the pterygo-maxillary fissure to the outer wall of the nasal cavity. It is recognized here by a finger introduced through the mouth. A fine saw is passed in this line and a ade to cut through the zygoma and malar bone upward into the spheno-maxillary fissure ; it then follows the floor of the orbit and ends just short of the lachrymal bone ; or the cut may be made with a chisel from before backward.

The saw is then re-entered into the pterygo-maxillary fissure at the outer extremity of the line of bony division at the lower border of the malar bone, and passing through the walls of the antrum very nearly in the line of the lower cutaneous incision enters the anterior nares close to the nasal floor. An elevator is now passed a second time into the pterygo-maxillary fissure, and the portion of the superior maxilla which has been separated is forced up till the free portion of the malar bone is brought into the middle line of the face. The attachments of this fragment consist of

the nasal bone and the nasal process of the superior maxilla, with the hitherto undisturbed periosteum and soft parts at the base of the original tongue-shaped incision.

A less satisfactory view of the naso-pharyngeal region is obtained if the floor of the orbit is preserved. The periosteum on the upper side of the orbital incision is not disturbed. The zygoma is cut through as before into the spheno-maxillary fissure. A chisel is driven from before backward in the line of the upper cutaneous incision through the anterior and outer walls of the antrum just below the orbital plate, then through these openings the inner wall of the antrum is divided. The chisel penetrates to the spheno-maxillary fossa. The lower line of bony division is the same as in the last method described, and the fragment is turned over in the same manner.

After the completion of the operation it is replaced and maintained in position by sutures or pressure.

Von Langenbeck's operation is difficult; it destroys the orbicular branches of the facial nerve, often damages the lachrymal duct, and gives very little better view of the nasal cavity than Guérin's partial extirpation of the superior maxilla.

OTHER METHODS OF GAINING ACCESS TO THE PHARYNX THROUGH THE NOSE.

These may here be described, although properly speaking they are not resections of the superior maxilla.

Borek's Operation. (Fig. 69, D, and Fig. 71, K.) The incision begins near the root of the nose slightly to one side of the median line. It passes in a curved direction down to the lower free border of the nasal bone; from here to the junction of the ala and cheek and a short distance outward on the cheek. The second incision passes from the origin of the first at the root of the nose along the edge of the orbit to the infra-orbital foramen. It must clear the lachrymal sac. This tongue-shaped flap is raised with the periosteum and exposes a triangular surface of bone. After retracting the soft parts a chisel is driven through the superior maxilla so as to divide it vertically

just inside the infra-orbital foramen between the margin of the orbit and the upper surface of the hard palate. The chisel should be obliquely directed and enter the nasal cavity near the vertical plate of the palate bone.

The nasal process of the superior maxilla and the nasal bone are cut very nearly in the line of the upper cutaneous incision. The lachrymal sac must be spared. The bony division is carried down to the lower free border of the nasal bone. Finally the chisel is driven into the nasal cavity through the anterior and inner walls of the antrum on a line reaching from the lower termination of the first bony incision to the floor of the nose.

The inferior and middle turbinated bones are removed with the mass thus marked out, which is more or less pyramidal in shape with the apex toward the posterior nares.

At the close of the operation the periosteum and skin are replaced and sutured in position.

Ollier turns the whole nose downward. He begins his incision at the edge of the bone close behind the ala of the

FIG. 73.



Ollier's operation for removal of a nasopharyngeal polyp. B. Modification for a very large polyp.

nose, carries it upward along its side to the highest part of the depression between the eyes, then across and down to the corresponding point on the other side (Fig. 73, A). The bone is sawn through in the line of the incision, the necessary liberating incisions made in the septum or the sides, and the nose turned down.

The septum is pressed aside, the polyp extracted, its base of implantation scraped, and the nose replaced.

A modification which is sometimes desirable on account of the size of the polyp or the distance of its implantation is indicated in Fig. 73, *B*. The incision runs more obliquely backward, and a transverse one is made from each end to the ala of the nose. The bone is divided in the direction of the cutaneous incisions, in the vertical one as before described, in the horizontal one by passing a fine saw across the nostrils through holes made between the bone and cartilages, and sawing backward. This line of section must be high enough to avoid the roots of the teeth.

In some cases it is sufficient to mobilize the *lower end of the nose* by an incision under the lip in the gingivo-labial fold, and then by carrying it and the lip upward very free access to the nasal fossæ is obtained.

Annandale,¹ after turning the lip and nose upward in this fashion, saws through the alveolus and hard palate in the middle line close to one side of the vomer. The soft palate may also be split if more space is required. The saw cut can then be made half an inch or more wide by prying apart the maxillæ. This affords a somewhat limited means of access to the naso-pharyngeal region.

EXCISION OF THE INFERIOR MAXILLA.

This may be total or partial; and partial excision may involve the removal of any part of the body of the bone or of the ascending ramus. Partial excision of the body may sometimes be accomplished through the mouth without the aid of a cutaneous incision, or by an incision along the lower border of the bone with or without another at right angles to it extending toward or even through the lip, or by two vertical incisions downward from the angles of the mouth when only the upper part of the body of the bone is to be removed.

When the ascending ramus also is to be resected the incision should pass along the lower border of the bone to the angle of the jaw, and then upward along the posterior

¹ *Lancet*, Jan. 5, 1889.

border of the ramus to the level of the lobule of the ear. If the incision is carried higher the facial nerve is necessarily divided with consequent paralysis of the muscles supplied by it, a complication which should be avoided. The horizontal portion of the incision should be a little below the border of the bone in order that the cicatrix may be less conspicuous. Syme removed the entire ramus with the condyle, without opening into the cavity of the mouth, by an incision slightly convex backward extending from the zygoma to, and a little beyond, the angle of the jaw.

The principal danger is of injury to the internal maxillary artery, which lies almost in contact with the inner side of the neck of the condyle. The lingual nerve also is in close relation with the inner side of the ramus, lying between it and the internal pterygoid muscle. Maisonneuve introduced a modification of the method of operating which has rendered it almost easy and has diminished the above-mentioned danger. It consists in separating the attachments of the condyle by twisting and tearing out the bone after all the connections have been divided. If this modification, which sounds, perhaps, rougher and less surgical than it really is, is not adopted, the joint must be approached from in front so as to avoid the external carotid, which lies close behind the bone in the substance of the parotid. It is sometimes allowable to divide the neck of the condyle, or even the ramus below the sigmoid notch, with cutting pliers, and leave the upper fragment in place.

Another danger is in the division of the attachments of the *genio-hyo-glossus* muscles to the bone. The tongue, deprived of its support, falls back upon and closes the glottis. As a preliminary, therefore, to any operation in which these attachments are divided, a stout ligature should be passed through the tip of the tongue and held by an assistant. After the operation it should be fastened to a harelip pin in the external incision, or to the skin of the face by a strip of adhesive plaster, and retained for a couple of days, at the end of which time the muscles will usually have formed new attachments.

The bone should be sawn through with a chain or common saw, according to circumstances, or merely nicked with the saw, and its division completed with cutting-pliers.

The tooth occupying the proposed line of section should first be drawn.

Ligature of one or both carotids has been proposed and performed as a preliminary operation to prevent excessive hemorrhage, but it has proved to be not only unnecessary but ineffectual. In Mott's case the main operation had to be adjourned to allow the patient to recover from the shock of the preliminary one. In another case in which both carotids had been tied, the main operation had to be abandoned on account of hemorrhage.¹ Syme says the preliminary ligation is unnecessary, because the only arteries that need to be divided are the facial and the transverse branches of the temporal, bleeding from which can be easily controlled, and, furthermore, all the advantages offered by ligation of the carotids can be obtained by their temporary compression during the operation.

The attempt should be made, when possible, to get primary union of the intra-buccal wound and to drain through the external one. This makes it easier to keep the wound sweet, diminishes the danger of purulent infection, and avoids the risks incident to the swallowing of the decomposing discharges.

The results of the operation are usually very good, and the deformity less than might be expected. Subperiosteal excision has been followed by reproduction of the entire bones with condyles and diarthrodial cartilages, and even when the periosteum is not preserved the cicatrix becomes very firm and fibrous, and able to support a plate with artificial teeth.

Resection of the Anterior Portion of the Body. This may be done by means of a vertical incision in the median line, or of a horizontal one below the free border of the bone, or from within the mouth without any cutaneous incision.

If one of the incisions is made, the external and internal surfaces of the bone are cleared through it, a tooth drawn at each of the proposed points of section, and the bone sawn through.

¹ Mentioned by Syme in *Contributions to the Pathology and Practice of Surgery*, Edinb., 1844, p. 19.

If no external incision is made, the external surface of the bone is cleared, beginning at the edge of the gum or in the gingivo-labial fold, according as the periosteum is or is not to be preserved, and the lip drawn down under the chin so that the bone protrudes through the mouth. It can then be easily sawn through and freed from its attachments on the inner side.

Resection of the Lateral Portion of the Body. The incision extends along the lower border of the jaw from its angle nearly to the symphysis, and then is carried vertically upward to the base of, but not through, the lip. The flap is dissected up, the elevator being used, of course, if the periosteum is to be preserved, the inner surface of the bone cleared near the symphysis for the passage of a chain-saw, and the section made if possible at a short distance from the median line, so as not to disturb the insertion of the genio-hyo-glossus. This section may be made with a narrow saw from before backward if preferred.

The bone is then drawn downward and outward, its inner surface cleared, and the saw applied behind the last molar tooth or at any suitable point.

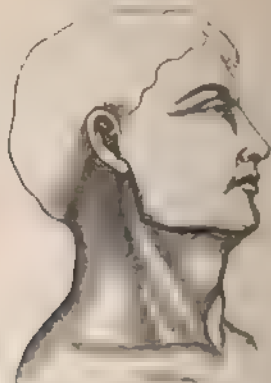
Dr. McBurney¹ has devised a remarkably efficient means of maintaining the proper relations of the remaining portions to each other until repair has taken place, and of thereby avoiding the great interference with function which formerly ensued.

Resection of the Ramus and Half of the Body. (Fig. 74.) An incision is begun close to the posterior border of the ramus on a level with the lobule of the ear, carried down to the angle of the jaw, and thence along its lower border to the symphysis, where it is met, if necessary, by a vertical one, beginning below the free border of the lip a little to that side of the median line on which the bone is to be removed. The flap thus marked out is dissected up from the bone as far as can be done without opening into the buccal cavity, and the divided facial artery tied. The inner surface of the bone is then cleared in the same manner, an incisor tooth drawn, and the bone sawn through.

¹ *Annals of Surgery*, 1894.

The jaw is then drawn downward and forward, the denudation of its inner surface completed by dividing the attachment of the mucous membrane and of the internal pterygoid, and the inferior dental nerve cut squarely across at the point where it enters the bone.

FIG. 74.



Excision of inferior maxilla.

The insertion of the temporal muscle upon the coronoid process is divided with curved scissors while the jaw is forcibly depressed, or the process itself is cut through if it is so long that its extremity cannot be reached.

The remaining soft parts are carefully detached upward toward the condyle, the knife, or better, the elevator or the handle of the scalpel, being kept close to the bone, and the separation completed by twisting the jaw out.

Excision of the whole of the Inferior Maxilla. The incision is made from the lobule of one ear down to the angle of the jaw, along the lower border of the bone to the other angle, and then up to the lobule of the other ear. The outer and inner surfaces of the jaw are denuded, the bone sawn through in the median line, and each half removed as before described.

In the *subperiosteal method* the incisions are the same, except that the vertical incision may be in the median line.

since the genio-hyo-glossus and genio-hyoid muscles remain attached to the periosteum. The attachment of the temporal muscle is not cut, but is fixed with the elevator, as is also that of the external pterygoid to the condyle.

Partial Excisions of the Inferior Maxilla. Removal of a portion of the alveolar process is often necessary in the operation for epulis. The teeth in the involved segment are drawn. The muco-periosteum at a sufficient distance from the growth is cut through and the bony segment thus marked out removed through the mouth with a chisel or rongeur.

If a portion of the body of the jaw is to be removed it should be approached by an incision along the lower border of the maxilla. Whenever possible the removal should be so limited as not wholly to destroy the continuity of the bone.

The part represented in Fig. 69 is the ordinary amount removed for epulis, and it can be accomplished through the mouth.

ANCHYLOSIS OF THE JAW.

The most common cause of ankylosis of the jaw is found in cicatricial retraction or adhesions left behind by intra buccal ulceration. Rizzoli (1858) was the first to point out that the proper aim of an operation intended to relieve this infirmity should be the establishment of a pseudarthrosis in front of the adhesions or cicatricial bands when the cause itself could not be removed. His operation consisted in the division of the inferior maxilla behind the last molar tooth by means of a specially constructed osteotome introduced through the mouth. Bony union of the fracture was then to be prevented by motion. Esmarck (1859) proposed the removal of a wedge-shaped piece of the bone. By some surgeons the base of the wedge is taken from the alveolar process, by others from the lower border of the jaw. Dieffenbach proposed to divide the ascending ramus horizontally from before backward by means of a chisel passed through the mouth to the anterior border of the ramus.

Operation (removal of wedge-shaped piece). An incision

is begun at the angle of the jaw and carried two inches forward along the lower border. A narrow strip of bone is then cleared on both sides up to the edge of the gum, just anterior to the masseter and in front of the contracted tissues, a tooth drawn if necessary, and the bone sawed through. The anterior fragment is then depressed and protruded through the wound, and a wedge-shaped piece from one-third to one-half of an inch in width at its widest part cut off with cutting forceps. (Fig. 69, I.)

Excision of the Condyle. This may be required for the relief of ankylosis due to bony or fibrous union between the condyle and the temporal bone. The incision is begun at the lower margin of the zygoma close in front of the temporal artery where it adjoins the ear, and carried forward along the zygoma about one and a quarter inches, the tissues being divided layer by layer until the bone is reached. A second incision, involving only the skin, is then carried from the centre of the first directly downward for about an inch. The soft parts are next carefully separated with knife and elevator from the margin of the zygoma and the outer surface of the joint and drawn downward with a hook, thus preserving the parotid, nerves, and vessels from injury. The neck of the condyle is then freed by working around in front and behind with a small elevator, keeping close to the bone, so as to avoid injury to the internal maxillary artery, and finally divided with the chisel and rongeur. If there is bony union between the condyle and temporal bone the chisel must be again used to separate them, its edge being kept directed somewhat downward, so as not to break through into the cavity of the cranium. The condyle is then grasped with forceps and twisted out. The knife or scissors may be used to sever any remaining connections, but must be kept close to the bone.

RESECTION OF THE STERNUM.

Ollier¹ reports the following case: Vertical incision four inches long; detachment of periosteum, and removal of a

¹ *Traité de la Régénération des Os*, vol. II, p. 52.

"red vascular sequestrum one and one-quarter inches square, adherent to the rest of the bone only by medullary granulations." The adjoining rarefied bone was gouged away, portions of the internal plate being left at a few points. The projecting and denuded ends of two costal cartilages, the fourth and fifth, were cut off.

Three years afterward the patient died of phthisis, and the autopsy showed reproduction of all the parts removed.

RESECTION OF THE RIBS.

This is best performed in those regions where the muscular layer covering the bone is thin. In the middle third of the rib the intercostal artery lies in a groove on the inner side of the lower border.

The incision should correspond in length and direction with the portion of bone to be removed, and may be crossed at each end by a short transverse one. The flaps are then dissected up, the periosteum separated as far as possible, a chain-saw passed at the limits of the diseased portion, and the piece removed. Instead of the saw, cutting-pliers may be used.

In *Fatlander's operation for empyema* (thoraco-plastik), in which portions of several adjoining ribs are resected to allow the chest wall to sink inward and unite with the visceral pleura, the position of the incision is usually determined by that of the fistula. The incision is made along the intercostal space occupied by the fistula, and the adjoining ribs dissected as above described. The limits of the cavity are then determined, and other ribs resected, if necessary, through a vertical incision made from the centre of the first. If the costal pleura is so thick as to prevent the attainment of the desired object, it must be cut away from a sufficient part of the area of resection. From three to six ribs have been thus resected, in lengths varying from one to three inches. The operation has been restricted to the ribs between the third and eighth, but in one case a small portion of the clavicle also was removed. Sometimes the thickened visceral pleura has also been dissected off.

EXCISION OF THE CLAVICLE.

On account of the proximity of the large vessels of the neck this has been considered the most dangerous of all the excisions. The danger, however, varies greatly with the nature and extent of the disease which renders the operation necessary. Thus, when there is osteitis with thickening and loosening of the periosteum, the operator can easily keep close to the bone, and the danger of injury to the vessels, as well as of exciting diffuse inflammation below the deep fascia, is reduced to the minimum. On the other hand, when caries has existed for a long time, the soft parts have become infiltrated and bound down, and the bone thickened and roughened, the difficulties are immensely increased; and when the bone is the seat of a malignant tumor, extending in all directions, its removal may tax the powers of the most skillful. Valentine Mott spoke of his case as the most difficult and tedious operation he had ever witnessed or performed; it lasted four hours, and more than forty ligatures were applied, including two upon the internal jugular vein.

As only the inner half of the bone is in close relation with the vessels, and the danger is especially great at the sterno-clavicular joint, it is advisable first to raise the outer end of the bone from its place by opening its articulation with the acromion or by dividing it a little to the inner side of that joint, and then, after clearing the posterior surface from without inward, to divide the attachments of the inner end while twisting the bone upward about its long axis, and keeping the edge of the knife against it. When this is impracticable the periosteum must be carefully separated near the middle, and the bone sawn through with the usual precautions against injury to the underlying parts. Each half is then raised in turn and dissected out.

For the removal of a tumor no fixed rules can be given. In other cases the directions are as follows:

Operation. The subperiosteal method must be employed throughout. The incision is made along the anterior surface of the bone, and corresponds in length with the portion to be removed. A short transverse incision is then made

at each end of the first, the flaps dissected up, and the denudation carried as far as possible around the bone above and below.

The bone is then freed at its acromial end, or divided in the middle, and the separation completed as above described.

EXCISION OF THE SCAPULA.

It is impossible to lay down fixed rules for making the incisions when the operation is rendered necessary by a tumor of the bone. They will be determined by the circumstances of the case, and especially by the extent of the disease, for while in some cases the acromial end of the clavicle must also be removed, in others the acromion and neck of the scapula may be left behind.

Mr. Holmes¹ says: "The surgeon turns down appropriate skin flaps. . . . When the whole tumor is thus exposed, the muscles inserted into the vertebral border of the bone should be rapidly divided, as also those which are attached to the spine of the scapula. The tumor should be lifted well up and freed from its other attachments, commencing from its lower angle. The subscapular artery is divided near the end of the operation, and can be held till the tumor is removed, or can be at once tied. The ligaments of the shoulder are then easily divided and the mass removed."

Gross² made a vertical incision sixteen inches long downward from the superior angle of the scapula, and circumscribed an oval portion by a second curved incision, beginning five inches below the upper end of the first and ending about the same distance above its lower end, and removed the bone after sawing through the acromion and neck of the scapula.

Velpaen³ recommends three incisions: one along the spine of the scapula, the others starting from the anterior extremity of the first and running, one toward the root of the neck, the other toward the axilla behind.

¹ A System of Surgery, vol. v. p. 669.

² Gross's System of Surgery, vol. i. p. 1078.

³ Medicine Opératoire, vol. ii. p. 60.

Syme made two incisions crossing each other near the centre of the tumor. Other surgeons have made triangular or semilunar flaps.

In January, 1878, Dr. George A. Peters removed, at the New York Hospital, the entire scapula for malignant disease, leaving the arm. He made an incision along the spine of the scapula, divided the fibres of the deltoid and trapezius, and exposed the tumor, which involved only the acromion and adjoining portion of the spine. He then made a vertical incision across the centre of the first, beginning two inches above it and extending to the inferior angle of the scapula, reflected the flaps, dissected out the under surface of the bone from behind forward, separated the acromion from the clavicle and humerus, and then, raising the lower angle of the scapula toward the head, approached the coracoid process from below, and found no difficulty in separating it from its attachments. Only two vessels required ligation, the supra-scapular and a large branch of the sub-scapular. The result was very good; six weeks afterward the wound had closed, and the patient possessed a certain degree of control over the humerus.

Subperiosteal Excision of the Scapula (Ollier). Fig. 75.

1. *Incision of the Skin and Muscular Interstices.* An incision is made along the whole length of the spine of the scapula, and from its posterior extremity two others are made, one following the posterior border down to the inferior angle, the other running obliquely forward and upward for about an inch. A short transverse incision may also be needed at the anterior end of the first.

2. *Denudation of the Bone.* The attachments of the deltoid and trapezius to the acromion and spine are separated, the periosteum of the posterior border of the scapula divided in the interstice between the rhomboideus and infra-spinatus, and the infra-spinous fossa carefully denuded. The periosteum is very thin in its lower third. The lower angle is freed by detaching the teres major and serratus magnus, the bone raised, and the subscapularis detached from below upward. If the marginal cartilage is not completely ossified and united with the bone, it should be separated and left adherent to the periosteum.

The supra-spinous fossa is then cleared, care being taken not to injure the supra-scapular nerve in the supra-scapular notch, but to raise it up with the periosteum and its fibrous sheath. The posterior part of the bone is then carried upward and forward, and the denudation of its under surface and anterior border completed.

If the extent of the disease permits, the denudation should stop at the neck of the scapula, which is then divided with a chain-saw or cutting forceps.

FIG. 75



Excision of the scapula.

3. *Opening of the Scapulo-humeral Joint. Detachment of the Articular Capsule and Denudation of the Coracoid Process.* The acromion is next separated from the clavicle, the scapula turned upward, the joint opened from below, and as the bone is pressed steadily upward everything that holds is detached with an elevator. After the coracoid process has been thus separated from most of its muscular and ligamentary attachments, the few that remain can be broken by twisting the bone away. In suitable cases the coracoid process may be divided at its base and left in

place, and thus the most difficult and laborious part of the operation done away with.

The partial excisions of the scapula do not require detailed description. The acromion, spine, and posterior border are reached by straight or slightly curved incisions along the portion to be removed. A crucial or H incision is required at the angles.

RESECTION OF THE HUMERUS.

The position of the musculo-spiral nerve is the most important element in this operation. In its passage around the posterior aspect of the humerus the nerve lies close to the bone within the sheath of the triceps muscle, and leaves the latter on the outer side of the arm to enter that of the supinator longus at its origin. In approaching the bone, therefore, on the outer side near the junction of the middle and lower thirds, the operator should lay bare the outer border of the brachialis anticus and follow down within its sheath to the bone.

Upper Portion. Same incision as in Ollier's method of excision of the shoulder carried further down along the outer edge of the biceps. The cephalic vein must be sought for and drawn aside. Periosteum and capsule divided, bone denuded and removed as in excision of the shoulder-joint (q. v.).

Middle Portion. Incision along the posterior border of the deltoid and outer edge of the biceps. Outer border of the brachialis anticus laid bare and followed down to the bone. Division of the periosteum and denudation of the bone, with especial care for the safety of the musculo-spiral nerve.

Ollier prefers to seek the nerve and draw it aside. He also recommends that whenever it is possible to leave a portion of the shaft connecting the extremities it should be done, as a precaution against shortening and the formation of a pseudarthrosis. If this is not possible the chainsaw is passed at two points, and the intermediate piece removed.

Lower Portion. Incision on outer side of the posterior

aspect of the arm, between the triceps and supinator longus, as in Ollier's excision of the elbow (q. v.).

Total Excision. Combination of incisions for upper and lower portions. After the ends have been denuded of periosteum the middle portion can be cleared by pushing one end out through its incision and peeling the periosteum back like the finger of a glove until the middle is reached. The bone is then sawn off, and the other half removed in a similar manner through the other incision.

EXCISION OF THE ULNA.

Longitudinal incision along the posterior aspect of the bone, joined at its upper end by a short one running obliquely upward and outward between the triceps and anconeus. The triceps is drawn to the inner side, and the olecranon freed. After separation of the periosteum the bone is sawn through in the middle, and each piece is dissected out in turn.

EXCISION OF THE RADIUS (OLLIER).

An incision involving the skin only is made from the styloid process of the radius along the outer border of the forearm to the radio-humeral articulation. The fascia is divided and the posterior border of the supinator longus found. By following it toward the wrist the knife can be kept between it and the extensor tendons of the thumb, which can then be drawn backward and saved from injury. By following it upward the interstice between it and the extensores carpi radiales is found, through which the operator penetrates to the radius now covered only by the supinator brevis. The latter muscle is then divided longitudinally and the periosteal sheath opened.

The periosteum is detached laterally, the bone sawn through at its middle, and each fragment removed separately.

Partial Excisions of the Ulna and Radius. The incisions and methods are the same as those above described.

EXCISION OF THE METACARPAL BONES AND PHALANGES.

The metacarpal bones should be exposed by a longitudinal incision along the dorsum. As the extensor tendons cross the bones obliquely this incision should involve only the skin at first, the tendon is then drawn aside, and the incision carried down to and through the periosteum, which must be retained when possible. It is advisable that the joints, especially the metacarpo-phalangeal, should not be opened.

The bone is then divided in the middle with cutting forceps and each end dissected out, or the gouge alone may be used.

The after-treatment is important. Extension must be made upon the corresponding finger for a long time to keep it from being drawn up into the hand. In the case of the metacarpal bone of the thumb lateral pressure must also be made.

For *resection of a phalanx* the incision should be made on the side of the finger near the dorsum. For the terminal phalanx the incision should be U-shaped, the arms passing along the sides of the phalanx, the curve around its end.

Resection of the different portions of the thumb, even if not subperiosteal, is to be preferred to amputation, but the contrary is true of the phalanges of the other fingers.

Lateral pressure, by means of splints or an India-rubber glovefinger, and extension by weight must be made to insure the necessary length and proper shape of the member.

RESECTION OF THE BONES OF THE PELVIS.

Ollier¹ reports a case in which he removed the ascending ramus of the ischium and most of the pubis for suppurative osteo-arthritis of these bones and the pubic synchondrosis. The incision was about four inches long and extended from a fistula in the genito-crural fold up toward the pubis. The

¹ De la Régénération des os, vol. II p. 120.

periosteum was detached, the ascending ramus of the ischium removed, and then the ascending ramus, body, and part of the horizontal ramus of the pubis. The bone that was removed was eroded and rarefied, but not necrotic.

EXCISION OF THE COCCYX (OLLIER).

This may be required on account of disease of the coccyx, or as a preliminary to operations upon the rectum. Ollier has removed it for osteitis, Simpson and Nott for the relief of coccygodynia, and Vernet in cases of imperforate anus, and to facilitate the removal of cancers of the rectum.

The limits of the bone are determined by the finger in the rectum, and a longitudinal incision made through the skin and fibrous covering of the bone, from a quarter of an inch above its upper to the same distance below its lower end, and a transverse incision made at the upper end of the first. The posterior surface of the bone is then denuded.

The sacro-coccygeal articulation having been opened by this denudation, its fibro-cartilage is divided, and the cornua cleared on both sides. An elevator is then passed through the joint and used as a lever to force out the coccyx, peeling off at the same time the fibrous covering of its anterior surface.

If the sacrum is also diseased, and the gouge is used upon it, it must be remembered that the sacral canal extends to its very end, and is there formed posteriorly not of bone, but of fibrous tissue.

RESECTION OF THE SHAFT OF THE FEMUR.

A longitudinal incision is made on the outer side in the groove between the vastus externus and biceps, with a transverse liberating incision at each end. Denudation is carried as far around as possible, the chain-saw passed at each end of the diseased portion, and the denudation completed as the piece is raised from its bed.

In the case of a child extension should be made, and the limb kept at the same length as the other; in the case of

an adult the fragments should be brought nearer together as the patient is older, and his power of regeneration less; and, in many cases, it is better to bring the fragments into contact. Shortening is less of an infirmity than pseudarthrosis.

RESECTION OF THE SHAFT OF THE TIBIA.

If the entire diaphysis of the tibia become necrotic it may be removed subperiosteally and a fairly useful limb obtained, especially in children. The incision is made parallel to and just in front of the internal border. At the upper end it lies behind the tendons of the sartorius, gracilis, and semitendinosus; further down the internal saphenous nerve is recognized and drawn to one side.

The periosteum is incised on this line, and raised with an elevator which should be well curved to get around the sharp angles of the bone. When the denudation has been completed, if the bone is not already detached, the elevator is used to press back and protect the soft parts behind, while the bone is chiselled or sawn through as close to the dead area as possible. A transverse incision through the periosteum at this point will save undesirable denudation of adjoining healthy bone.

The operation is most frequently required to remove the necrosed fragments which may result from a compound fracture or an osteomyelitis.

It is wise to delay interference till separation of the fragment has occurred, and then the location of the incision will depend largely on the position of the sinuses. In general it should extend between the two which are most widely separated; or, if there is only a single sinus, the centre of the incision should correspond to this. It is made in the long axis of the limb as already described, and the periosteum elevated.

If there is an involucrum, it must be chiselled away very freely on each side of the central cavity, so as practically to abolish the latter, and the sound bone at each end of this cavity must be freely cut away, so as to leave a surface sloping easily down to the bottom (posterior wall) of the

cavity. The object of this free removal of bone is to permit the soft parts to come everywhere into contact with the bone when they are brought back and sutured together over it. No anxiety as to subsequent weakness of the bone need be felt, for the new formation of bone will be ample.

If it is necessary to reach the tibia on its external surface the skin incision should lie a little to the outer side of the crest. The periosteum is cut into close to the anterior border of the bone, and elevated with the attached tibialis anticus muscle. When the gap after a compound fracture involves the entire thickness of a portion of the shaft, a corresponding length must be removed from the shaft of the fibula to secure good apposition of the parts. The fibula is best approached at some distance above or below the site of the tibial injury, as thus there will be less danger of infecting this fresh wound, and subsequent immobility can be more readily secured.

The posterior surface of the tibia is best approached around its internal border. At the upper extremity the incision is made as already described behind the sartorius, gracilis, and semitendinosus, and the periosteum elevated with the attached popliteus muscle.

RESECTION OF THE FIBULA.

The lower portion of the fibula is subcutaneous, its upper portion is covered by the peroneal muscles. The biceps is attached to its head, and the external popliteal or peroneal nerve, after following the posterior border of the tendon of that muscle, winds around the outer side of the neck of the fibula, and divides into the anterior tibial and musculo-cutaneous, the latter of which soon becomes superficial. Sometimes this division, and even the subsequent ones, take place as high up as the head of the fibula, and then there is danger of dividing some of the branches during resection of the upper extremity of the bone, unless the method indicated by Ollier is strictly carried out. The earlier authors considered the division of this nerve unavoidable.

As the upper tibio-fibular articulation communicates in a large proportion of cases with that of the knee, it should

not be opened, except when it shares in the disease. The head of the fibula should be divided or gouged out in such a way as to leave this articulation covered by a thin but complete plate of bone.

Resection of the Upper Extremity of the Fibula (Ollier).¹ A longitudinal incision is begun an inch above the head of the fibula at the posterior border of the tendon of the biceps, and carried down a little behind the bone along the interstice between the soleus and the peroneal muscles. The incision should involve only the skin and fascia.

The nerve is then sought for where it passes around the neck of the fibula, and protected by two blunt hooks placed about an inch apart. While thus protected, it is freed from the cellular tissue, which binds it to the bone, and then drawn forward so as to permit the division of the periosteum. This division is made on the posterior border of the bone, and carried downward as far as is necessary in the interstice between the soleus and peroneal muscles.

The periosteum is then detached and the bone removed, either by dividing it at two points with a chain-saw or chisel and removing the intermediate portion, or by dividing it at the lower limit of the disease, and twisting out the upper fragment, or by modifying the latter method to the extent of dividing the head of the bone with a sharp chisel in such a manner as to leave the tibio-fibular joint unopened.

Resection of the Lower Portion of the Fibula. Longitudinal incision along the antero-external aspect of the bone. Denudation and removal of the bone in the usual manner. For other details, see excision of the ankle-joint.

EXCISION OF THE WHOLE FIBULA.

As the incisions for the resection of the upper and lower portions lie on opposite sides of the peroneal muscles, they cannot be made continuous with each other. Each half of the bone must be removed separately.

¹ *Traité de la Régénération des Os*, p. 207.

EXCISION OF THE BONES OF THE FOOT.

Calcaneum. Disease of the tarsal bones is apt to originate in the calcaneo-astragaloid articulation and then involve the calcaneum mainly, the astragalus being only superficially affected. The disease in the former is usually central, leaving a sequestrum inclosed in a shell of rarefied vascular bone, or a cavity is formed within a similar shell by ulceration and discharge through one or more fistulae. The removal of the entire thickness of the bone gives better results than simple gouging out of the diseased portions, *évidement de l'os*, but the anterior portion should if possible be left, as it favors reproduction of the bone.

The English surgeons do not usually employ the subperiosteal method, claiming¹ that the results obtained by the ordinary method are so good that they are disinclined to make any change. So far as can be judged from the published descriptions, these results, although satisfactory so far as the restoration of function is concerned, are inferior to those obtained by the superiosteal method. The absence of the calcaneum destroys the plantar arch and the sightliness if not the usefulness of the foot, whereas in some of Ollier's superiosteal cases the new heel was as prominent and firm as that of the other foot.

A. Holmes's Method. An incision is commenced at the inner edge of the tendo Achillis, and drawn horizontally forward along the outer side of the foot to a point somewhat in front of the calcaneo-cuboid articulation. This incision should go down at once upon the bone, so that the tendon should be felt to snap as the incision is commenced. It should be on a level with the upper border of the os calcis. Another incision is then made vertically across the sole, commencing near the anterior end of the former incision and ending at the outer border of the internal surface of the os calcis. The bone being now denuded by throwing back the flaps, the calcaneo-cuboid and calcaneo-astragaloid joints are sought for and laid open. The calcaneum having been thus separated from its bony connections by the free

¹ Holmes System of Surgery, vol. v. p. 730

use of the knife, aided, if necessary, by the lever, lion-forceps, etc., the soft parts are next to be cleaned off its inner side with care, in order to avoid the vessels, and the bone will then come away.

B. Superficial Method (Ollier.) Fig. 76, A. An incision involving only the skin is begun at the outer border of the tendo Achillis about an inch higher than the tip of the external malleolus, carried down below the outer tuberosity of the calcaneum and then forward and slightly upward to the upper part of the base of the fifth metatarsal. The edge of the tendo Achillis and the upper border of the plantar muscles being recognized, the incision is carried down to the bone, care being taken not to cut the peroneal tendons.

FIG. 76.



A Excision of the calcaneum
B Excision of the astragalus

The posterior half of the bone is then denuded with an elevator, and the tendo Achillis detached and pressed to the inner side. The under surface and posterior third of the inner surface are next cleared, the peroneal tendons drawn aside with blunt hooks, the external lateral ligament detached, the anterior portion of the outer surface denuded, and the calcaneo cuboid joint opened.

The interosseous ligament is divided with a narrow bistoury, the bone grasped with lion-forceps and turned downward so as to open the calcaneo-astragaloid joints and give access to the calcaneo-scapoid and internal lateral ligaments and to the inner surface of the bone.

It is difficult, if not impossible, to avoid opening some of the tendinous sheaths during the operation, but the damage is very much less than that inflicted by the former method.

Resection of the posterior portion alone can be accomplished much more expeditiously. The portion to be removed is denuded and then sawn off, either directly or by

perforating the bone and sawing it from above downward with a chain-saw.

C. Parareuf's Method. (Fig. 77, C.) The incision begins opposite the base of the fifth metatarsal bone exter-

FIG. 77.



- A. Excision of astragalus. (Voigt)
 B. Excision of ankle
 C. Excision of calcis. (Parareuf)

nally, and is carried horizontally backward just above the margin of the sole. It passes on the same level around the back of the heel and is prolonged forward about an inch on its internal aspect. A second incision extends from this about two inches vertically upward beside the external border of the tendo Achillis. These incisions involve the skin only. The vertical cut is now deepened and the periosteum divided in this line, taking care not to damage the peroneal tendons which lie just anteriorly. The periosteum with the associated ligaments is elevated first on the outer surface, aided by deepening the horizontal incision in this part down to the bone. The attachment of the tendo Achillis is cut and the posterior aspect cleared as far as possible.

The periosteum of the anterior end is next separated together with its attached ligaments, and afterward the plantar area is denuded. The anterior extremity is grasped with forceps and twisted outward, while the remaining attachments are severed with the knife, which must be

kept close to the bone. The superior surface is reached through the outer incision and the interosseus ligament cut. By careful work with the elevator the internal surface is freed from the periosteum and attached ligaments and the bone finally removed without damage to the vessels and nerves on its inner side.

Astragalus. Excision of the astragalus may be rendered necessary by dislocation, comminuted fracture, or caries, or it may be made as a preliminary step in excision of the ankle. Ollier considers this operation, under normal circumstances, the most difficult of all excisions. He employs the following method on the cadaver:

Operation (Ollier). Fig. 76, B.—Curved incision across the dorsum of the foot, with convexity directed forward, beginning on the inner side at the point where the tendon of the tibialis anticus crosses the tibio-tarsal articulation, running forward and outward to the middle of the scaphoid, and then backward to a point a little below the tip of the external malleolus. This incision must expose but not involve the tendons.

The extensor tendons are lifted out of their sheaths and drawn aside, the extensor brevis cut across or detached at its origin, and the neck and outer non-articular surface of the astragalus cleared. The capsular and ligamentary attachments of the bone to the scaphoid and tibia are separated, the interosseous ligament divided, and the foot being turned inward the insertion of the strong internal tibio-astragaloid ligament is detached. The remaining connections are then ruptured by grasping the bone with strong forceps and twisting it out.

Vernieuil thinks the operation is made easier by sawing through the neck of the bone and first removing the head.

See also Vogt's (Fig. 77) excision of the ankle, p. 195.

When *dislocated* the astragalus may be easily removed by a straight, curved, or crucial incision made over the most prominent part, and avoiding vessels, nerves, and tendons.

When *badly shattered*, as in gunshot injury, the fragments may be removed through a longitudinal incision between the extensor tendons of the first and second toes.

For simultaneous removal of the calcaneum and astragalus see *Osteoplastic excision of the foot*, p. 159.

Metatarsal Bones and Phalanges. A metatarsal bone should be exposed by an incision along the dorsum involving only the skin; the tendon is then drawn aside, the periosteum divided, the bone denuded, sawn through, and removed. Whenever possible, the upper extremity of the bone should be left.

For the first and fifth metatarsals it is better to make the incision more upon the side than upon the dorsum.

If the corresponding toe is to be preserved, extension must be made upon it for a long time, in the manner and for the reasons mentioned under excision of the metacarpal bones.

The phalanges and their articulations are best excised by lateral incisions.

TREPHINING.

Trephining of the Cranium may be undertaken for the evacuation of an intra-cranial abscess or hemorrhagic effusion, or for the removal of a suspected tumor of the brain or meninges, or for the cure of epilepsy, or after fracture to raise depressed portions of the bone. In all except the latter case the advisability of the operation may be diminished by the difficulty of determining the point at which the trephine should be applied. Among the more or less trustworthy indications, according to which the surgeon must make his selections of this point, may be mentioned: the history of an injury more or less recent,¹ with or without pain and inflammation of the soft parts (Pott's puffy tumor) at the point where the injury was received; constant, well localized pain at any one point; injury over the course of one of the larger meningeal arteries with rapidly supervening symptoms of compression, functional disturbance of certain groups of motor nerves.

The results obtained by certain physiologists in their efforts to determine the location of motor centres in the cortex of the brain have inspired the hope that the injured or

¹ In a case of Dupuytren's there was no sign of the abscess until ten years after the receipt of the injury.

compressed portion of the brain might be localized exactly in any given case by consideration of the muscles or groups of muscles paralyzed. This hope has been in part realized and surgical interference has been successfully based upon paralytic symptoms in fracture of the cranium, abscess of the brain, tumor of the brain, intra-cranial hemorrhage, etc.

To secure success in the operative surgery of the brain, the most scrupulous asepsis must be observed. The head is to be entirely shaved twenty-four hours before operation, and cleaned, and the fissures of Rolando and Sylvius and any other desired landmarks painted on the skin with iodine. After the administration of the anæsthetic, and before any incision is made, the scalp should be punctured with an awl or some sharp instrument to mark upon the skull the position of the guiding-line and the exact spot for the application of the trephine point. This is for reference after the skin has been divided and retracted.



Trephine

The incision is horseshoe shaped, with base downward, in order to secure the best nutrition for the flap, and so situated that it can be enlarged if found necessary later on. It should be made three-fourths of its expected length with one sweep of the knife. After the vessels have been tied it is enlarged to its intended size. The pericranium is not dissected up with the skin flap, but is afterward elevated from the area of bone to be removed. In general the trephine hole should be at least one and a half inches in diameter, and if more room is needed it can be enlarged by the rongeur, or two trephine holes can be made and the intervening bone chiselled or sawn away. If Horsley's electric saw is used a thin, flat steel instrument must be kept beneath it between the bone and the dura to protect the latter.

The centre-pin of the trephine having been protruded one-sixteenth of an inch and fastened in its place by the binding screw on the side, it is forced by to-and-fro rotatory movements upon its point into the bone at the place selected, and these movements continued until the

circular edge of the trephine has cut a groove sufficiently deep to insure its steadiness without the aid of the pin, which must then be withdrawn, so as to avoid injury by it to the dura mater. The rotatory movements are continued very cautiously, and all parts of the groove frequently examined with a probe, as its depth increases, so as to have timely notice of complete perforation.

The teeth of the trephine must be freed from dust from time to time by means of a brush or by dipping the instrument into sterilized water. If, as is usually the case, perforation takes place upon one side of the groove before it does upon the other, the trephine must be slightly inclined so as to act only upon the unsawn portion; or a thin-bladed elevator may be used to lift or pry out the disk, breaking the thin shell which remains.

It is possible to replace even large plates of bones and secure bony union, although the attempt more often fails. If this is to be attempted, wrap the fragment removed in a towel dampened with a 1 to 2000 solution of bichloride of mercury, or immerse it in a plain sterilized salt solution, and in either case keep it at the temperature of 99° F.

Hemorrhage from the diploe is checked by simple sponge pressure or by plugging the larger vessels with decalcified bone, softened catgut, a piece of aseptic sponge, or Horsley's wax. This is made of wax 7 parts, oil 2 parts, carbolic acid 1 part. The dura mater is cut one-quarter of an inch from the bony margin, and the incision should have a horseshoe shape. It is lifted carefully to avoid injury to the vessels of the pia, as the hemorrhage from these may be profuse and troublesome. Any arteries on the dura are ligated before their division by passing a small curved needle.

Hemorrhage from the pia or brain is checked by sponge or gauze pressure. If these fail the vessels are clamped and tied with fine catgut ligatures. The Paquelin cautery may be used as a last resort. The brain can be punctured cautiously with a probe or hypodermic needle, but all lateral movements should be avoided. (Edema of the pia is evacuated by a few small incisions aided by the pressure of a sponge.

If the brain has to be incised pass the knife through the

summit of a convolution, as the hemorrhage is less than when the incision is made at the bottom of a sulcus. A clot can be wiped out with fine sponges or picked out with forceps. An encapsulated tumor is enucleated with curved blunt-pointed scissors, aided by the finger. But one that infiltrates the brain must be cut out with the knife. The use of the sharp spoon is not allowable in this situation.

A superficial cyst is either enucleated, or, after cutting off its superficial surface, it is simply packed and drained. A deeper cyst is evacuated and packed or continuous drainage maintained by a strip of rubber tissue. A cavity remaining after the removal of a cyst or tumor is packed with gauze, which is removed gradually to prevent the space filling with a blood clot. A clot may be allowed to form if there is perfect confidence that asepsis has been maintained. If bulging of the brain occurs the protruding part should be held back by a thin spatula, which is gradually withdrawn as the dural incision is closed over it by a continuous catgut suture. If it is impossible thus to hold the brain back the protruding part may be sliced away or wiped off with a sponge. True hernia cerebri after an operation is rare when perfect asepsis has been maintained.

Any alarming hemorrhage from a sinus or large vein can usually be checked by gauze pressure; if this fail artery clamps can be applied and left in the dressings for several days. A bleeding sinus has been sutured successfully, but it is difficult. At the close of the operation a folded strip of rubber tissue is passed as a drain beneath the dura, which is stitched with catgut except at this point, and brought out of the lower angle of the skin wound. Often the drain is unnecessary, and the wounds in the dura and skin may be closed up tight, the former with catgut, the latter with silk, and dressed aseptically.

Temporary Resection of the Skull by Omega Flap. The incision takes the form of a Greek Ω , with base downward to secure the best nutrition to the flap. Everything is divided down to the pericranium. The horizontal feet of the loop are each about half an inch long and separated from each other across the base by at least an inch of sound skin. The size of this pedicle varies with that of the flap,

its width being a good half of that of the latter. The horizontal cuts serve as liberating incisions to facilitate the turning down of the flap with its attached bone. The dimensions of the loop can of course be made to vary to suit the requirements of each case, but as used by Wagner.¹ They are follows: Vertical length, 6.5 c.m.; greatest breadth, 5 c.m.; with a pedicle of undivided sound tissue, 3 c.m. wide.

After the soft parts have retracted the periosteum is cut close up and parallel to the inner edge of the skin in the loop and its horizontal continuations below, and the bone chiselled through along the entire curved portion. A periosteal elevator is cautiously pushed in as a lever at the top of the curve and the bone flap snapped at its base by a sudden quick application of force and laid back without disturbing the attached parts. It may be necessary to aid this breaking by chiselling of the outer table from either or both angles part way across the bone. The dura is opened as described in the operation of trephining. When the bone fragment is replaced it is held in position and prevented from pressing unduly upon the dura by the projecting spicules of the vitreous plate formed by the fracture. The skin flap overlaps the line of bony division about one-quarter to one-half an inch, and is united by interrupted silk sutures, with or without drainage in the lower angle of the wound. By this method it is claimed the bone can be replaced with less danger of necrosis than when it has been entirely separated from its sources of nutrition, and if it does necrose it is just as easy to remove as in the cases where the bone has been replaced after an ordinary trephining.

This is the description of the operation as given by its originator, but practically the horizontal "feet" of the *Q* may generally be dispensed with. Their only use is in liberating skin incisions to facilitate the turning down of the flap. If needed they can be made after the section of the bone.

To chisel through the skull, two gouges, one larger than the other, will be found most useful. The outer table is divided with the larger instrument, the inner table with the smaller one along the groove made by the first.

¹ *Centralblatt f. Chir.*, 1889, p. 452.

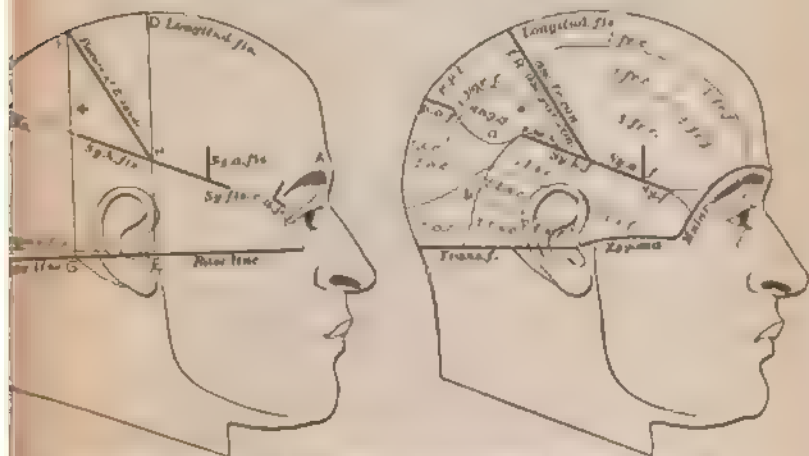
Cranicectomy (Lannelongue) An incision parallel to and a finger-breadth to one side of the longitudinal sinus is made from the lambdoid to the coronal suture. The periosteum is elevated in this line, and at one extremity of it the skull is perforated with a half-inch trephine. Then with the rongeur or chisel a strip of bone from a quarter to half an inch wide and from four to six inches long, parallel to the sagittal suture and about an inch distant from it, is excised. This has sometimes been extended to reach from the frontal eminence nearly to the transverse sinus.

A similar strip of bone has occasionally been removed at the same time from the opposite side of the head, and Lannelongue has performed the operation in the transverse diameter of the skull, the incision and excised bone corresponding nearly to the coronal suture. A flap, concavity downward, is sometimes fashioned so as to prevent the lines of skin and bone division from coinciding.

Trephining for Fracture of the Skull. The scalp is shaved and cleaned over all the surrounding area. If a wound already exists it is enlarged; if not, a semilunar incision is made and placed with due regard to the arteries leading into the flap. The periosteum is divided and detached and the fracture examined. It is generally possible after removing loose fragments with dressing forceps to introduce an elevator and pry up the depressed portion, using of course only the sound part of the skull as a fulcrum. If some projecting fragment of bone prevent this it may be chiselled away enough to admit of lifting or prying up the depressed part. When the trephine is used the point is so placed on the sound bone that about one-third of the cutting edge only overlaps the injured area, and the rest will expose any widespread comminution of the inner table. If there is reason to think a sinus has been wounded, the trephine opening should be planned to give ready access to the bleeding point. All splinters and loose fragments are taken out with care to strip off any adherent dura on the inner surface; but depressed fragments still retaining a hold on sound bone are simply elevated and left. Wounds of the dura are sutured with fine catgut, and hemorrhage from it is checked by gently applied pressure

or ligature. Bleeding from a diploic vein is stopped by plugging its lumen with aseptic sponge or catgut or by crowding in a little of the surrounding bone tissue. After thoroughly cleaning all parts of the wound and removing every hair or trace of dirt, it is closed with interrupted silk and drained at the most dependent angle.

FIG. 79



B. Placette of the brain. e. d. p. External angular process of frontal bone. Sg. a. f. Ascending limb of Sylvian fissure. P. Parietal eminence. F. G. D. D. E. Perpendicular to base line locating the fissure of Rolando. F. H. p. o. f. Parieto-occipital fissure. 1. fr. f. First frontal fissure. 2. fr. f. Second frontal fissure. asc. f. con. Ascending frontal convolution. i. p. o. f. Intra parietal fissure. a. m. c. Supra marginal convolution. ang. g. Angular gyrus. 1. t. s. c. First temporo-sphenoidal convolution. 2. t. s. c. Second temporo-sphenoidal convolution. 3. t. s. c. Third temporo-sphenoidal convolution. 1. t. s. f. First temporo-sphenoidal fissure. 2. t. s. f. Second temporo-sphenoidal fissure. MARKS.

The Relation of the Brain to the Overlying Parts. Reid's method.¹ The "base line" is drawn through the lowest part of the infra-orbital margin and the centre of the external auditory meatus.

The great longitudinal fissure is marked by a line running in the middle line of the skull from the glabella to the external occipital protuberance.

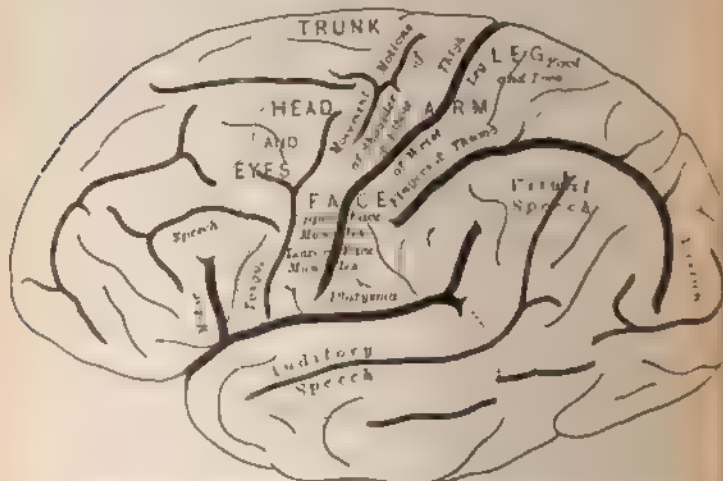
¹ Lancet, September 27, 1901.

The *transverse fissure*, or the fissure of Bichat, by one from the external occipital protuberance through the auditory meati.

The *Sylvian fissure* starts one and one-quarter inches horizontally behind the external angular process of the frontal bone, and extends to a point three-quarters of an inch below the most prominent part of the parietal eminence.

The *ascending line* of this fissure starts at a point in this line two inches behind the external angular process, and ascends vertically about one inch.

FIG. 80.

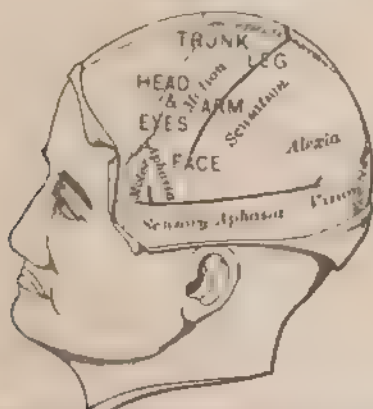


Showing the location of the centres on the cortex of the brain. Frank.

Fissure of Rolando. Draw a perpendicular to the base line starting in the depression in front of the external auditory meatus, and another perpendicular to the base line starting from the posterior border of the mastoid process at its root. The fissure of Rolando is indicated by a line drawn from the intersection of this second line with the line marking the great longitudinal fissure, to the point of intersection of the anterior perpendicular with the horizontal line of the fissure of Sylvius already laid out. A simpler way of indicating the Rolandic fissure is to draw a line three an-

three-eighths inches long at an angle of 67° with the sagittal meridian of the head, from a point which lies back of the glabella in this meridian 55.7 per cent. of the distance from the glabella to the inion. Cheyne's method of measuring this angle is to halve a right angle by doubling a square piece of paper into a triangle, and then halve the 45° thus obtained by folding one of the triangles. By unfolding the crease first made, leaving the last unchanged, there results the sum of 45° and $22\frac{1}{2}^{\circ}$, or $67\frac{1}{2}^{\circ}$, which is near enough for all practical purposes. The line three and three-eighths inches long is then laid off at this angle by means

FIG. 81



showing the position of the cortical centres with reference to the Sylvian and Rolandic fissures marked on the surfaces of the skull. (STARK.)

of the folded bit of paper from a spot half an inch behind the mid-point between the glabella and the external occipital protuberance.

The parieto-occipital fissure. The horizontal limb of the fissure of Sylvius is prolonged to meet the longitudinal fissure. A trephine opening over the *inner inch* of this line will reveal a whole or part of the parieto-occipital fissure. It varies slightly up or down in its location.

The frontal lobe lies between the lines indicating the fissures of Rolando and Sylvius and the longitudinal fissure and a line drawn from the glabella close to and parallel to

the supra-orbital arch to meet the prolongation of the Sylvian fissure.

The first frontal fissure is indicated by a line drawn from the supra-orbital notch parallel to the longitudinal fissure and ending three-quarters of an inch in front of the fissure of Rolando.

The second frontal fissure is indicated by the frontal part of the temporal ridge.

The ascending frontal convolution occupies a space three-quarters of an inch broad in front of the fissure of Rolando.

The parietal lobe lies between the fissure of Rolando, the horizontal limb of the fissure of Sylvius, the longitudinal and parieto-occipital fissures.

The intra-parietal fissure begins on the horizontal limb of the Sylvian fissure—more correctly a little above it—one inch behind its junction with the fissure of Rolando, and passes upward three-quarters of an inch behind the latter for the first third of its length. Then it arches backward and downward and passes half an inch to the outer side of the outer extremity of the line indicating the parieto-occipital fissure.

The ascending parietal convolution lies between the fissure of Rolando and this first third of the intra-parietal fissure.

The inferior parietal lobule lies between the horizontal limb of the Sylvian fissure and the intra-parietal fissure.

The supra-marginal convolution occupies the anterior portion of this space in the most prominent part of the parietal eminence.

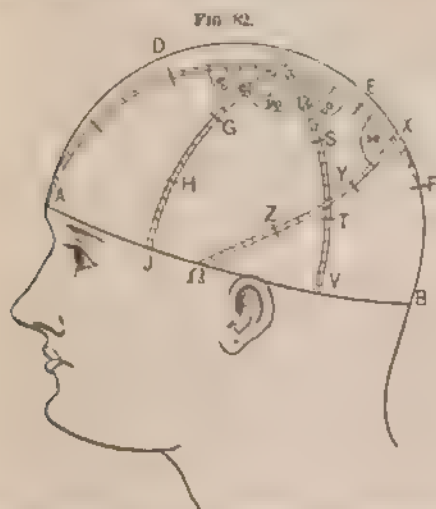
The angular gyrus occupies the posterior portion.

The temporo-sphenoidal lobe lies between the Sylvian fissure and the base line, and is limited behind by a line joining the termination of the horizontal limb of the Sylvian fissure, with the centre of the line from the external occipital protuberance to the posterior border of the root of the mastoid process.

The first temporo-sphenoidal fissure is indicated by a line parallel to and one inch below the Sylvian fissure.

The second temporo-sphenoidal fissure by a line three-quarters of an inch below this.

Kocher's Method. Kocher uses a specially constructed instrument of pliable steel bands to mark out the position on the shaved scalp of the different parts of the brain which lie beneath. By reference to the figure the nature of this instrument can be readily understood. An ordinary



Kocher's cranial topography. (All the points on the sagittal meridian, D, C, E, X, lie further back than indicated in this figure.)

metal tape measure can be made to answer the purpose. The band A D C E B extends from the glabella along the median line to the lowest point of the external occipital protuberance.

The horizontal band A J Q V B is placed at right angles to this around the side of the head between the same two points. For convenience the lines thus marked out are called the sagittal and horizontal meridians of the head.

From the centre, C, of the sagittal meridian two bands each at the same angle of 60° to the sagittal meridian pass downward to meet the horizontal meridian at the points J and V.

The sagittal meridian is now divided into thirds, the last of which begins at E; and next into fourths, the last of

which begins at F. At a point midway between E and F the band X Y Z Q passes at right angles to the sagittal meridian to join the horizontal at Q, which is usually about half an inch behind J. This oblique band X Q is divided into thirds at Y and Z. C J and C V are also divided into thirds at G, H, S, and T. The horizontal meridian marks the lower border of the cerebrum. The point J lies about at the pterion or junction of the frontal parietal and sphenoidal bones, and marks the anterior end of the Sylvian fissure at the spot where the ascending joins the horizontal limb. It also indicates the point of contact of the frontal and temporal lobes. V lies over the boundary between the temporal and occipital lobes, and is one centimetre below the edge separating the outer and under surfaces of the brain.

C indicates the uppermost point of the anterior central convolution, and is in front of the fissure of Rolando. At G the anterior central convolution meets the first and second frontal convolutions, and at H the second and third. S lies over the intra-parietal fissure just above the supra-marginal gyrus. T indicates the posterior extremity of the first temporo-sphenoidal fissure and is below the angular gyrus. X is over the apex of the lambdoidal suture and at the point of meeting of the parieto-occipital and great longitudinal fissure. Q indicates the anterior extremity of the first temporo-sphenoidal fissure. The posterior end of the first third of the sagittal meridian, D, is at the bregma.

A trophine opening close to one side of C reaches the centre for the lower extremity—the thigh and leg are near the middle line, the foot and toes slightly posterior.

Between H and G is the centre for the upper extremity, in the upper part and in front of the fissure of Rolando the shoulder and elbow, and in the ascending parietal convolution a little lower down the centre for the wrist, fingers, and thumb.

A little above H the trophine exposes the centre for the upper face muscles, just below H the lower face muscles. A finger-breadth directly above Q lies the centre governing the movements of the larynx and pharynx.

In front of the middle of the line H J is the centre, injury to which produces motor aphasia.

The auditory centre lies under the posterior half of the line Z Q.

The centre for visual aphasia is below the point T, and just above the line B V is the centre for psychical vision or psychical blindness.

C. Winkler¹ has elaborated another system of cerebral topography, and Langdon² still another. D'Antona's³ method is simple and easily applied, but as Reid's original scheme and its modifications are most generally known and used, it has not seemed worth while to do more than call attention to these few of the numerous others which have recently been devised.

THE POSITION OF THE LATERAL SINUS.

According to Birmingham⁴ the limit of the up-and-down variation of the position of the lateral sinus is determined thus: At a point one and a half inches behind the centre of the external auditory meatus it begins to arch downward. Measure this distance along the base line. Then, at a point one and a quarter inches above the base line at this spot, draw a line slightly convex upward to a point half an inch *above* the external occipital protuberance. Take another point half an inch *below* the external occipital protuberance and connect it with the point on the base line one and a half inches behind the centre of the meatus. Outside of these limits there is no danger of opening the lateral sinus.

In its average location it extends from the external occipital protuberance, gradually rising to a point three-quarters of an inch above Reid's base line. The highest point is reached one and a half inches *behind* the centre of the external auditory meatus. From here with a gradual or sharp turn it runs downward and forward on the inner

¹ *Nederlandsch Tijdschrift voor Geneeskunde*, 1892, p. 158.

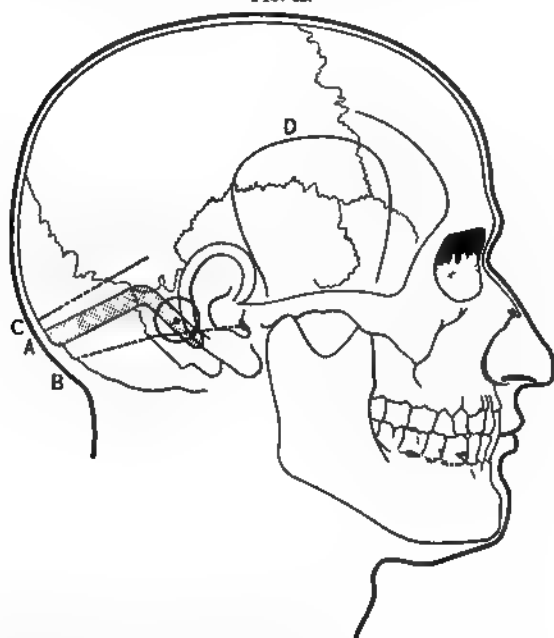
² *Canad. Med. Journ.*, Aug. 16, 1894.

³ *Annals Surg.*, Dec. 1892.

⁴ *Dub. Journ. Med. Science*, 1891, p. 116.

surface of the mastoid portion of the temporal bone immediately in front of a ridge, which on the outer surface of the skull sometimes prolongs the posterior margin of the mastoid process upward and backward and in front of the

FIG. 83.



A. External occipital protuberance and lateral sinus.

B. } Limit of up and down variation in position of the lateral sinus.

C. }
D. Incision for exposure of the Gasserian ganglion.

posterior margin of the process itself. Here it lies about half an inch behind the meatus. At the level of one-quarter or one-sixth inch below the floor of the meatus it turns into the base of the skull.

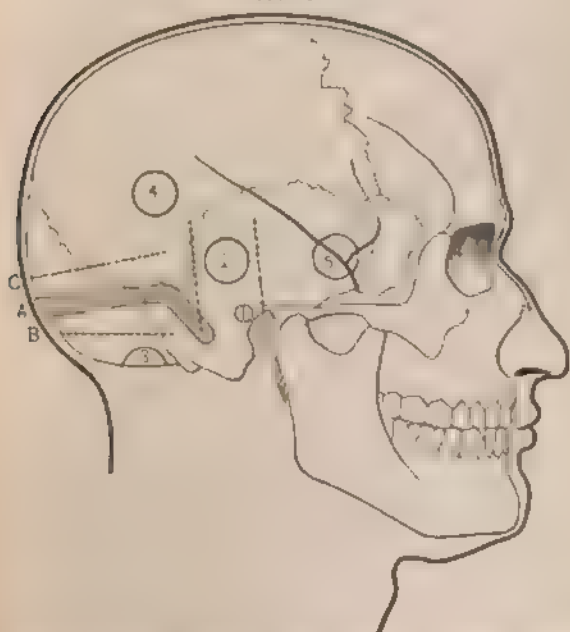
To Open the Lateral Sinus. Incision about two inches in length, starting near the lower end of the mastoid process, and passing upward along the ridge on its posterior margin. The periosteum is divided and elevated. The

pin of a three-quarter-inch trephine is placed at a point one and one-quarter inches behind the centre of the external auditory meatus on a level with its upper border. According to Birmingham this will always open up the sinus. The opening in the bone may be enlarged as circumstances require.

TREPHINING FOR CEREBRAL ABSCESS DUE TO SUPPURATIVE DISEASE OF THE MIDDLE EAR.

The pus in these cases is most frequently found in the temporo-sphenoidal lobe—next in order of frequency in

FIG. 84.



1 Trephine opening to enter the mastoid antrum. 2 Trephine opening for abscess following otitis media. 3 Trephine opening to expose the cerebellum. 4 5 Trephine opening for middle meningeal hemorrhage. A lateral sinus. B-C Limit of its up-and-down variation.

the cerebellum. According to Barker¹ the abscess generally occupies a space between two lines drawn perpendicular to Reid's base line. The first passes through the centre of the meatus, the second one and one-quarter inches behind this (Fig. 84, 2.)

A semilunar incision, convexity downward, is made just above and behind the pinna. The periosteum is divided and elevated sufficiently for the use of a three-quarter-inch trephine. The pin of this is placed one and one-quarter inches above the base line in the centre of the space enclosed by the perpendiculars. Birmingham² shows that in a certain proportion of cases a trephine thus applied will come down on the bend of the lateral sinus, and proposes as a safer location to place the point of the trephine at least one and three-quarter inches above the base line, or, better still, two inches.

Keen places the pin of the trephine an inch and a quarter behind and the same distance above the external auditory meatus.

After the removal of the button of bone the dura is incised with the knife, and the opening enlarged in the shape of a crucial incision with blunt-pointed scissors. The abscess is located with an aspirating needle, and an opening large enough for a drainage tube is made with some blunt instrument.

The flaps are then adjusted and partially sutured in position, leaving sufficient room for the escape of pus.

TREPHINING OF THE CEREBELLUM.

A transverse incision is made along the superior curved line of the occiput. Everything is divided down to the bone. The sterno-mastoid, trapezius, and underlying muscles are raised with the periosteum. These soft parts will contain the divided occipitalis minor and major nerves and the occipital artery. The skull is opened below the superior curved line and behind the masto-occipital suture by placing the pin of a three-quarter-inch trephine one inch below

¹ British Medical Journal 1887, vol. 1, p. 407.
² Dublin Journ. Med. Science, 1891, p. 112.

Reid's base line at a point two inches behind the centre of the external auditory meatus measured along the base line (Fig. 84, 3).

Barker advises one and one-half inches behind the centre of the meatus and one inch below the base line, but Birmingham says a three-quarter-inch trephine would wound the occipital artery in many cases in this situation.

PUNCTURE OF THE LATERAL VENTRICLES (KOCHER).

An inverted U-shaped incision is made to expose the skull at T (Fig. 80). The enclosed flap should be about one and one-half inches long by an inch wide. After turning down the skin and securing the vessels the periosteum is incised and elevated, and the point of the trephine entered just below and in front of T. The skull is thin in this region. This exposes the posterior end of the first temporo-sphenoidal fissure. The posterior horn of the lateral ventricle lies about 1 cm. distant from the bottom of the sulcus directly inward.

Another method of locating the opening to be made in the skull (Keen) is to measure one and one-quarter inches back of the external auditory meatus along Reid's base line and then one and one-quarter inches vertically upward. At this point apply the pin of a half-inch trephine. After incising the dura push a grooved director or trocar in a straight line toward a spot about two and one half or three inches above the opposite meatus. The ventricle will normally be reached at a depth of about two inches—if distended it lies somewhat nearer the surface—and can be recognized by the diminution of resistance offered to the instrument and the escape of fluid along the groove of the director. Drainage is provided for by inserting a small rubber tube or a folded strip of rubber tissue.

TREPHINING FOR MIDDLE MENINGEAL HEMORRHAGE.

An inverted U-shaped incision is made from the upper part of the posterior border of the frontal process of the malar

bone upward nearly to the temporal ridge, and thence backward and downward in a gentle curve, to terminate at the superior border of the posterior extremity of the zygoma. This flap, including a part of the temporal muscle, is turned down and the bone sufficiently bared of periosteum to admit the use of the trephine at the spot presently to be indicated.

Kocher makes an incision from the external angular process of the frontal bone to the eminentia articularis, thence upward and backward for about an inch in front of the ear.

Wagner¹ employs the *Z* flap with osteoplastic resection of the skull, the same as for exposure of the second and third divisions of the fifth nerve within the cranium (see p. 215).

After the soft parts have been raised the skull is opened over the anterior division of the artery by placing the pin of a three-quarter inch trephine a thumb's breadth behind the external angular process of the frontal bone and two finger-breadths above the zygoma. Both divisions can be exposed simultaneously by applying the trephine immediately above the middle of the zygoma (Kocher).

Kronlein determines the location of the branches by drawing a line through the upper border of the orbit backward parallel to Reid's base line. The anterior division of the artery lies on the upper line 3 to 4 cm. behind the external angular process of the frontal bone, and the posterior at the intersection of the upper line with another drawn perpendicular to the base line from a point 3 to 4 cm. behind the external auditory meatus—roughly, from about the posterior border of the mastoid process.

The following may be taken as accurate enough for all practical purposes: To expose the anterior division of the artery apply the pin of a three-quarter inch trephine one inch above the middle of the zygoma, and then enlarge the opening downward with the rongeur if it is found necessary to secure the trunk of the vessel. If for the latter purpose the method by osteoplastic resection of the skull is em-

¹ *Centralb. f. Chir.* 1899, p. 323.

ployed, the bone should be chiselled through in the lines of the lower extremities of the inverted U incision, down to the level of the zygoma or nearly to the pterygoid ridge on the greater wing of the sphenoid.

To expose the posterior division of the artery apply the trephine just below the most prominent portion of the parietal eminence.

Any clot which may be found is scooped or irrigated out, and the bleeding points in the dura are secured by ligatures passed around them by means of a fine curved needle. Hemorrhage from the trunk of the middle meningeal as it lies in its bony canal may be checked by packing with gauze or strands of catgut.

RESECTION OF THE SECOND AND THIRD DIVISIONS OF THE FIFTH NERVE WITHIN THE SKULL.¹

The omega-shaped incision is used with its base on the zygoma and the top of the curved part at the temporal ridge. It starts at the external angular process of the frontal bone, and passes horizontally along the upper border of the zygoma for about half an inch. Thence in the curved portion upward to the temporal ridge and down to the zygoma and again horizontally about half an inch to the tragus of the ear. The periosteum is divided and the bone chiselled through and turned down with its attached soft parts, as already described.

The middle meningeal artery is secured by passing a sharply curved needle and ligature beneath it, and the dura is carefully separated from the bone below so as to expose the middle fossa of the skull. Any hemorrhage is checked by pressure.

With broad retractors the dura and brain are lifted, taking great care to avoid injury to the other cranial nerves in the immediate vicinity. The first, second, and third divisions of the fifth nerve, as well as the carotid artery and cavernous sinus are well exposed. The dura is stripped back from the second and third divisions to beyond the

¹ Hartley N. Y. Med. Journ., 1893, vol. 55, p. 317.

Gasserian ganglion, and the parts lying between it and the foramen ovale and rotundum are excised. The flap is then replaced and united with interrupted silk sutures.

OPENING OF THE FRONTAL SINUS.

The eyebrow is shaved. The incision starts at the centre of the supra-orbital ridge and follows the curve of the upper border of the eyebrow to the median line above the root of the nose. Everything is divided down to the bone—the periosteum is raised on each side and the trephine or chisel entered at the inner end of the superciliary ridge.

Antrum of Highmore. A very small trephine should be used, and, in order to avoid a scar, it should be applied through the mouth after dividing the gingivo-labial fold, and dissecting up the soft parts as far as to the infra-orbital foramen, just below and to the outer side of which the opening into the antrum should be made.

The antrum may also be opened by drawing the first or second molar tooth, and enlarging its socket with a drill.

No additional directions are needed for trephining the *flat bones* or the *epiphyses of the long ones*.

PART V.

NEUROTOMY AND TENOTOMY.

DIVISION AND RESECTION OF NERVES.

DIVISION of a nerve of sensation, or even of a mixed nerve in extreme cases, may be required for the relief of neuralgic pain. It is seldom that simple division is more than temporarily sufficient. At least half an inch of the trunk of the nerve should be excised, and, as additional security against reunion, the end of the distal segment may be bent back upon itself. Prof. Weir Mitchell¹ has seen severe constant pain follow the bending back of the end of the proximal segment.

SUPRA-ORBITAL NERVE.

The *frontal* nerve, main branch of the first division of the trigeminus, divides just behind the upper margin of the orbit into the *supra-orbital* and *supra-trochlear* nerves; both branches are distributed to the forehead, the former emerging from the orbit through the supra-orbital notch or foramen, the latter a little nearer the nose. The former is much the larger and more important of the two, the latter supplying only a narrow strip of integument near the median line. The supra-orbital notch or foramen is found at the junction of the inner and middle thirds of the supra-orbital arch, or a little to the inner side of the junction. When it is a notch it can be readily felt through the skin, and is then an important guide in the operation.

The nerve may be divided subcutaneously after its emer-

¹ A description of all known operations on cranial nerves, with the bibliography, can be found in *Chir. Opérat. du Syst. Nerveux*, by Chipault. Paris: Rueff & Co., 1894.

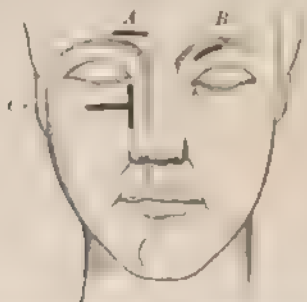
² Oral communication.

gence from the notch, or it may be exposed by a transverse incision above or below the eyebrow.

Subcutaneous Division. A tenotomy knife is entered between the eyebrows midway between the nerve and the median line, and passed horizontally beneath the skin until its point has passed beyond the nerve. Its edge is then turned backward and pressed against the bone, and the nerve, lying between it and the bone, divided by withdrawing the knife. Or the knife may be entered at the same point, but passed close to the bone instead of just under the skin, its edge turned downward toward the margin of the orbit, and the nerve divided by sweeping the knife downward across the mouth of the supra-orbital foramen.

Excision of a Portion of the Nerve. *A. Above the Eyebrow.* (Fig. 85, *A*.) An incision one to one and a half

FIG. 85.



A, A. Excision of supra-orbital nerve. *B.* Excision of superior maxillary nerve.

inches long is made just above and parallel to the eyebrow, its centre corresponding to the position of the nerve. This incision is carried down to the bone, the distal end of the nerve recognized, seized with forceps, dissected out, and cut off.

B. Below the Eyebrow. (Fig. 85, *B*.) The eyebrow being drawn up and the eyelid down, the surgeon makes an incision one to one and a half inches in length along the edge of the supra-orbital arch, dividing successively the skin, lacrimal muscle, and tarsal ligament. He then seeks the

nerve in the notch, traces it back as far as necessary, while depressing the eye and levator palpebræ with a retractor, and cuts out a portion with curved scissors.

Supra-trochlear Nerve. König resected this nerve by making a curved incision under the eyebrow at the upper inner edge of the orbit, and seeking the trochlea and the superior oblique muscle. On making the latter tense with a hook the two fine nerves became visible, were seized with forceps, and resected.

SUPERIOR MAXILLARY NERVE.

After leaving the cavity of the cranium by the foramen rotundum, the superior maxillary nerve crosses the spheno-maxillary fossa, traverses the infra-orbital canal, and appears upon the face at the infra-orbital foramen, where it at once divides up into numerous branches distributed over the cheek, nose, lip, and lower eyelid. Within the infra-orbital canal it gives off the anterior dental branch, and posterior to this canal it gives off the posterior dental, and through branches to the spheno-palatine ganglion, the palatine nerves distributed to the palate and nasal fossa. The point at which the nerve should be divided will vary according to the region affected; but in this, as in other cases, simple division has usually proved insufficient, and it has been found necessary to excise all that portion of the trunk which lies in the canal. Sometimes the nerve has been cut above the branches going to the ganglion, and the latter torn out forcibly.

The roof of the infra-orbital canal is composed in its posterior half of fibrous tissue, in its anterior half of thin bone, which becomes thicker as it approaches the margin of the orbit. The infra-orbital foramen lies directly above the second bicuspid tooth and from one-quarter to one-half an inch below the margin of the orbit. The nerve is accompanied on its passage through the canal by the infra-orbital artery.

A. Division of the Nerve on the Face. This may be done: (1) *subcutaneously*; (2) *through the mouth*; (3) *by an external incision*.

1. *Subcutaneously.* A tenotomy knife is entered about an inch to the outer side of the foramen, carried below it into the canine fossa, hugging the bone, and then swept upward along the surface of the bone so as to divide the nerve close to the foramen, the lip being drawn downward and forward to make the tissues tense.

2. *Through the Mouth.* An incision is made in the gingivo-labial fold, and the soft parts dissected away from the bone until the nerve is reached and divided. Guérin advises that a small portion of the distal end be excised.

3. *By External Incision.* The incision may be transverse, oblique, or curved; it is only necessary that its centre should correspond to the foramen. The tissues are divided successively until the bone is reached and the nerve found either by following up one of its branches or by seeking it at its point of emergence.

B. *Resection of the Infra-orbital Portion.* (Tillaux' Fig. 85, C.) A vertical incision is made along the side of the nose from the lachrymal tubercle or the bony ridge of the nasal process of the superior maxilla, which is continuous with the lower edge of the orbit, down to the ala of the nose. A second horizontal one is then begun at the upper portion of the first and carried outward along the lower margin of the orbit beyond its centre. These incisions should involve all the soft parts down to the bone. The lower flap is dissected up, the nerve found, and a silk ligature thrown around it close to the foramen.

The upper flap is then raised, together with the lower eyelid and eyeball, exposing the floor of the orbit as far back as possible, upon which the infra-orbital canal can be recognized as a grayish line running obliquely backward and inward.

The canal is opened with a knife or chisel, the nerve isolated from the artery, raised from its bed with a curved hook, and dissected out as far back as may be considered necessary. It is then divided with curved scissors, and the distal portion drawn out by means of the ligature applied

¹ Traité d'Anat. Topographique, p. 210, and Bull. de la Société de Chirurgie 1878, p. 413

to it in the beginning. The length of the portion removed by Tillaux was six centimetres.

Dulbeau¹ divided the nerve with curved scissors on the central side of the branches going to the sphenopalatine ganglion, and tore out the ganglion by drawing upon the nerve.

Malgaigne's Method. Pass a stout tenotome along the floor of the orbit for nearly an inch in the direction of the nerve; cut transversely with its point through the floor of the orbit; the bone being thin will offer no resistance. This divides both canal and nerve. Expose the nerve at the infra-orbital foramen by a simple transverse incision, seize it with forceps and tear it out of the canal.

The first part of this operation has been modified by Von Langenbeck and Hueter as follows: A strong tenotome with slightly blunted point is entered close below the external palpebral ligament and pushed backward and downward along the outer wall of the orbit until its point is felt to leave the bone and enter the fissure; its edge is then turned forward against the sharp border of the orbital process of the superior maxilla and made to scrape along it as the knife is brought forward.

*Lucke's Method.*² An incision, beginning one centimetre above the outer angle of the eye and close behind the margin of the orbit, is carried downward and slightly forward across the malar bone, dividing its periosteum; from its lower end a second incision is carried backward and upward, terminating over the outer surface of the zygomatic process of the temporal, about a quarter of an inch behind its junction with the malar bone. The latter bone is next divided in the line of the first incision by means of a saw or chisel, after preliminary division of the soft parts and periosteum on its under and inner surface with a small knife, and the zygoma then cut through at its posterior extremity. The attachments of the masseter to the intermediate piece are then separated, and the flap of bone and soft parts raised with a sharp hook.

If necessary, some of the anterior fibres of the temporal muscle should now be divided in order to expose the sphenopalatine

¹ Oral communication.

² Deutsche Zeitschrift für Chirurgie, vol. 4, p. 322.

maxillary fossa thoroughly, the fat occupying the fossa pressed backward with a retractor, and the spheno-maxillary fissure recognized with a probe. The nerve and artery can be distinguished by the difference in their course, the former running downward, outward, and forward, the latter upward, inward, and forward. The nerve is seized with forceps and divided with a tenotome well forward in the fissure, and then again with scissors as near as possible to the foramen rotundum. The flap is then put back, and the wound drained at its lower angle.

An objection to this method is that, in consequence of its interference with the masseter and temporal muscles, the mouth subsequently cannot be freely opened. Lossen and Braun¹ avoid this difficulty by leaving the attachments of the masseter untouched and turning the flap downward instead of upward, after making the second incision from the upper end of the first instead of from its lower end, and separating the temporal fascia from the malar bone. Czerny² has employed this modification five times with good results.

If wounded vessels cannot be seized and tied, the hemorrhage must be arrested by plugging with antiseptic gauze.

INFERIOR DENTAL NERVE.

This nerve may be divided (A) after its exit from the dental canal, (B) in the canal, (C) before its entrance into the canal. The nerve enters the canal by the inferior dental foramen on the inner side of the ascending ramus of the lower jaw at the level of the crowns of the lower teeth; the canal runs obliquely downward and forward just below the alveoli, and the nerve emerges through the mental foramen which lies midway between the alveolar process and the lower margin of the jaw below the second bicuspid tooth.

A. At the Mental Foramen. An incision is made in the gingivo-labial fold above the foramen, and the soft parts

¹ *Centralblatt für Chirurgie*, 1878, pp. 65 and 145.

² *Ibid.*, 1882, p. 249.

dissected off until the nerve is reached, usually about one-third of an inch below the bottom of the fold.

B. Within the Canal. An incision is made through the skin down to the bone along the course of the nerve in front of the masseter, the periosteum raised, and the canal opened with a chisel or small trephine. After removal of the outer table of the bone the nerve is easily found in the canal and divided.

Or the canal may be opened at two points and the intermediate portion of the nerve excised.

A better method is to make a curved incision behind and below the angle of the jaw, and elevate the periosteum and masseter on its outer surface as far as the alveolar margin. Then chisel into the middle of the exposed bone. The oral cavity should not be opened.

C. Before its Entry into the Canal. 1. *From within the mouth.* The mouth being held widely open and the commissure of the lips drawn backward and outward, an incision extending from the last upper to the last lower molar tooth is made one-third of an inch on the inner side of the sharp anterior border of the coronoid process, and carried through the mucous membrane to the tendon of the temporal muscle.

The surgeon passes his finger into the incision and along the inner surface of the bone, between it and the internal pterygoid muscle, until he touches the bony point which marks the orifice of the canal. Passing a blunt hook along the finger, he raises the nerve upon it, isolating it, if possible, from the accompanying artery, and divides it with blunt-pointed scissors or knife. Or, without introducing the finger, the hook may be passed back beyond the nerve, its point constantly in contact with the bone, then rotated inward so as to carry its point across and behind the nerve, and then withdrawn.

2. *Through the cheek.* A curved incision is made around the angle of the jaw or around the lower anterior insertion of the masseter and carried through to the bone along its lower portion; then with the elevator and knife the muscle is detached from below upward, and the flap raised with a

hook until the level of the inferior dental foramen is reached. The bone is then cut away with a chisel or small trephine and the nerve exposed and excised.

With the same curved incision around the angle of the jaw the inner surface of the latter may be freed from the periosteum and internal pterygoid muscle upward till the lingula is felt. Then, with or without dividing this process the nerve can be isolated and divided, or a vertical incision may be made through the skin and fascia, the fibres of the masseter separated, and the bone thus exposed.

At the Foramen Ovale. Braun's modification of Lücke's method for exposing the superior maxillary nerve can be employed with slight changes for this purpose. The temporal muscle must be retracted or partially divided near its insertion, or the coronoid process cut through at its base.

Krönlein¹ suggests the following method: An incision is made from half an inch behind the angle of the mouth to terminate a similar distance in front of the lobule of the ear. Only the skin and subcutaneous fat are divided, the buccinator and oral mucous membrane being spared. The masseter is cut back to the anterior border of the parotid gland, thus sparing the latter and Steno's duct, which lies well above the line of incision. The coronoid process is bared at its base with a periosteal elevator, divided from the semilunar notch downward and forward, and drawn upward, together with the attached temporal muscle. The branches of the inferior maxillary nerve are then exposed by a blunt dissection on the outer surface of the internal pterygoid muscle. The external pterygoid is drawn upward and the nerves traced back to the base of the skull. At the close of the operation the coronoid process and divided masseter muscle are sutured.

He exposes the superior and inferior maxillary nerves simultaneously at their exit from the skull in the following manner: A curved incision, concavity upward, is made, starting from the most prominent portion of the malar bone, passing down to the level of the lobule of the ear, thence

¹ Archiv f. klin. Chir. Bd. xlii. p. 12.

² Deutsch. Zeitsch. f. Chir., 1884, vol. xx. p. 494.

backward and upward in a gentle curve, to terminate over the posterior extremity of the zygoma. The flap of skin and subcutaneous fascia is turned up, the temporal fascia divided along the upper border of the zygoma, and the latter sawn through at its anterior and posterior extremities, as in Lucke's operation. The coronoid process is exposed and cut through at its base downward and forward, and drawn upward with the attached temporal muscle. The internal maxillary artery is secured and the attachment of the external pterygoid muscle separated from the under surface of sphenoid bone. This exposes the inferior maxillary nerve at the foramen ovale, and by working along the sphenomaxillary fissure the superior maxillary nerve is found and followed back to the foramen rotundum. At the close of the operation the parts are replaced and sutured in their proper position.

*Sulzer*¹ recommends a curved incision, convexity upward, extending from one extremity of the zygoma to the other. Everything is divided down to the skull, the zygoma sawn through at each extremity, and the flap of skin, fascia, temporal muscle, and zygoma turned down. The coronoid process is depressed by opening the mouth, and the nerve found below the external and on the outer surface of the internal pterygoid muscle, and divided as high up as desired.

BUCCAL NERVE.

The buccal nerve, a branch of the inferior maxillary, is not infrequently the seat of painful and persistent neuralgia. It is best approached through the mouth by the following method:

The surgeon places his finger-nail upon the outer lip of the anterior border of the ascending ramus of the lower jaw at its centre, and divides in front of this border the mucous membrane and the fibres of the buccinator vertically. He then seeks for the nerve, separating the tissues with a director, and divides it.

Zuckerkandl exposes the nerve from the outside of the

¹ *Wien. med. Wochenschr.*, 1887, vol. xxxvii. p. 461.

cheek. A horizontal incision a finger's breadth below the zygoma is made from the anterior border of the masseter muscle nearly to the canine eminence. The fascia overlying Steno's duct is divided, and the latter exposed and drawn downward with its accompanying nerves. The tail on the posterior part of the buccinator muscle is torn through, and the nerve found to the inner side of the insertion of the temporal muscle on the front of the coronoid process. It lies about an inch back of the anterior border of the masseter muscle.

LINGUAL NERVE.

Division of this nerve may be required for the relief of pain in cases of carcinoma of the tongue.

When the mouth is opened widely the pterygo-maxillary ligament can be readily seen and felt as a prominent fold behind the last lower molar, and the lingual nerve can be felt just below the attachment of the ligament on the inner side of the lower jaw, close to the bone below the last molar tooth.

The tongue should be drawn aside by an assistant, the mucous membrane divided for about an inch parallel to the margin of the alveolar process, beginning at the last molar tooth over the position of the nerve, or, according to Chassagel,¹ one-fifth of an inch from the attachment of the mucous membrane to the side of the tongue. The nerve is then readily found in the submucous tissue, raised upon a hook and divided, or a portion excised.

Moore's Method. Mr. Moore has employed the following method successfully in five cases: He cuts the nerve about half an inch from the last molar tooth, at a point where it crosses an imaginary line drawn from that tooth to the angle of the jaw. He enters the point of the knife nearly three-quarters of an inch behind and below the tooth, presses it down to the bone and cuts toward the tooth. This necessarily divides the nerve. This projection of the alve-

¹ *Précis d'Opérations de Chirurgie*, p. 435.

olar ridge might protect the nerve from a straight bistoury, and therefore a curved one should be used.

The lingual nerve may also be reached from outside the mouth by any one of the methods for resecting the inferior maxillary, or by an incision along the lower border of the jaw just in front of the masseter muscle. In the latter case (Lobker) the upper margin of the wound is drawn up and a portion of the inferior maxilla, where the alveolar process adjoins the ramus, is excised and the nerve exposed on the outer surface of the internal pterygoid. Or the dissection can be carried up under the inner surface of the jaw (Luschka). The submaxillary gland is displaced downward and forward, the posterior border of the mylohyoid muscle divided and the nerve found under the posterior end of the sublingual gland. Thence it can be followed backward and upward and divided as high as desired.

FACIAL NERVE.

This nerve has occasionally been stretched and crushed for the relief of clonic spasms of the corresponding muscles. A semilunar incision is made around the lower attachment of the ear with a short liberating incision downward from its centre; the flaps are dissected back, and the nerve exposed by drawing the parotid forward and outward.

The nerve is more easily exposed at the posterior border of the ramus. For this an incision is made from just in front of the tragus of the ear to the angle of the jaw. After dividing the parotid fascia the cervico-facial branch will probably be exposed first, and can then be followed back to its junction with the temporo-facial.

BRACHIAL PLEXUS.

This plexus consists of the four lower cervical nerves and the greater part of the first dorsal. It crosses the floor of the subclavian triangle of the neck, and lies between the anterior and middle scaleni muscles. Its shape

is triangular, with the base at the spine and the apex to the outer side of the subclavian artery below the clavicle.

Operation. The head and neck are extended, and the face turned to the opposite side. An incision, starting half an inch above the clavicle in the interval between the sternocleido-mastoid and trapezius, is carried forward, for about three inches, parallel to the anterior border of the latter. The skin and platysma are divided and the external jugular vein either cut between two ligatures or drawn to one side. The deep cervical fascia is divided in the line of the external incision, avoiding the supra-clavicular branches of the cervical plexus, and the outer border of the anterior scalenus muscle recognized. The plexus is felt with the finger just outside the latter and isolated by a little careful dissection. Any particular cord can be identified by tracing it to its point of emergence from the spine through the interval between the scaleni muscles.

Resection of the posterior roots of the brachial plexus. This operation has been performed several times for severe neuralgia of the peripheral branches. An incision about six inches long, with its centre just above the spine of the seventh cervical vertebra, is made parallel and close to the ligamentum nuchæ and deepened alongside of the spines till the laminae of the fifth, sixth, and seventh vertebrae are reached. These laminae are then bared of soft parts on the affected side out to the bases of the articular processes, and removed with the chisel, rongeur, or bone forceps, thus exposing the posterior roots of the nerves previous to their exit from the intervertebral foramina.

CERVICAL PLEXUS.

An incision about two inches in length is made parallel to and over the posterior border of the sterno-mastoid muscle. Its centre should correspond to the centre of the muscle. The skin, superficial fascia, and platysma are divided and the superficial branches of the cervical plexus are exposed at the middle of the posterior border of the

sterno-mastoid muscle and can be traced back toward the spine.

SPINAL ACCESSORY NERVE.

Anatomy. After passing outward beneath the digastric and stylo-hyoid muscles and occipital artery, the nerve about half an inch below the apex of the mastoid process enters the under surface of the sterno-mastoid muscle in its upper part, leaves it at about the centre of its posterior border, and passes beneath the trapezius at about the junction of the middle and lower thirds of its anterior border. In the substance of the sterno-mastoid muscle it communicates with the second cervical nerve, in the occipital triangle with the second and third, and beneath the trapezius with the third and fourth cervical nerves.

Operation. An incision about three inches in extent is made downward from the tip of the mastoid process along the anterior border of the sterno-mastoid muscle, the cervical fascia divided, and the muscle strongly retracted to put the nerve on the stretch. The nerve is then sought for external to the jugular vein about an inch and a half below the tip of the mastoid process on the fascia covering the rectus capitis anticus major. If it is not immediately apparent the nail of the index finger may be drawn across the bottom of the dissection to irritate the filaments (recognized by contraction of the sterno-mastoid and trapezius muscles), and thus help to locate the nerve.

Section of the posterior divisions of the first, second, and third cervical nerves for spasmodic wry neck. The chief posterior cervical rotators of the head and their nerve supply are as follows: The rectus capitis posterior major is supplied by the suboccipital or posterior division of the first cervical nerve. The inferior oblique is supplied by the posterior divisions of the first and second cervical nerves, and the splenius capitis by the posterior divisions of the second and third cervical nerves.

Operation. (Modified from Keen.)¹ A transverse in-

¹ *Annals Surg.*, Jan., 1891.

cision about three inches long is made extending horizontally outward from the middle line of the neck, or slightly overlapping it, an inch and a half below the external occipital protuberance. It is carried through the trapezius and posterior border of the splenius capitis muscles until the complexus is recognized; the trapezius is dissected up from the complexus, and the occipitalis major nerve found at the upper part of the complexus. Divide the complexus transversely and follow the nerve back to its origin from the posterior division of the second cervical nerve, and divide the latter as near the vertebra as possible.

Recognize the suboccipital triangle, which is bounded by the superior and inferior oblique and the rectus capitis posterior major muscles. Within this lies the suboccipital nerve close to the occiput and vertebral artery; it must be traced and severed close to the spine. The posterior division of the third cervical nerve is found beneath the complexus about an inch lower down than the occipitalis major, and must be cut close to the bifurcation of the main trunk.

Smith¹ made a longitudinal incision about three inches long from the occiput downward about an inch and a half to one side of the middle line. It passed through the trapezius to the edge of the splenius, then through the complexus, and eventually exposed the posterior divisions of the cervical nerves. The great occipital nerve was recognized, separated, and drawn aside; a part of the external branch of the posterior division of the second nerve was excised; the splenius and complexus separated from the parts beneath, and the entering nerve filaments divided.

The suboccipital nerve was not divided. The result of this operation seems to have been perfect.

Median Nerve. In the arm it is exposed by the method given for ligation of the brachial artery. At the wrist it is reached by an incision about an inch and a half long, parallel to and just to the ulnar side of the tendon of the palmaris longus.

¹ Brit. Med. Journ., 1893, vol. 1, p. 752

Ulnar Nerve. Except in the extreme upper part of its course the nerve closely accompanies the triceps and is completely separated from the median nerve and brachial artery by the fascial septum that passes down to the bone between the biceps and triceps. Except near the elbow, it should be sought through an incision parallel to and a little posterior to the brachial artery, and after exposure of the triceps.

Above the elbow it can be easily found through an incision an inch and a half long, curving upward between the internal epicondyle and the olecranon.

In the forearm its course is indicated by a line drawn from the space between the internal epicondyle and the olecranon to the radial side of the pisiform bone. At first, it lies over the flexor profundus beneath the flexor carpi ulnaris. At the wrist it is superficial, and lies on the annular ligament with the ulnar artery on its radial side. It is easily reached at the wrist by an incision about two inches long extending upward through the skin and fascia from the pisiform bone. The incision is parallel to and close to the radial side of the flexor carpi ulnaris tendon.

MUSCULO-SPIRAL NERVE.

Anatomy. It winds around the humerus in the musculo-spiral groove between the internal and external heads of the triceps, and reaches the outer side of the arm at about the junction of the middle and lower thirds, and is accompanied by the superior profunda artery. It then pierces the external intermuscular septum and descends in the groove between the brachialis anticus and supinator longus to the front of the external condyle. At this point it is most easily found.

Operation. An incision about three inches long is made at the upper part of the supinator groove, the fascia divided, and the nerve sought in the bottom of the groove; it is then followed upward or downward, according to the circumstances of the case.

Great Sciatic Nerve. An incision three or four inches long is made vertically downward from the gluteal fold, midway between the tuberosity of the ischium and the great trochanter. After division of the skin and fascia the lower border of the gluteus maximus is observed and the hamstring muscles recognized.

The nerve lies on the external rotators of the thigh just in front of and to the outer side of the hamstring muscles.

Internal Popliteal Nerve. It is reached by the incision for ligation of the popliteal artery. It is superficial to the vein and artery and slightly external.

External Popliteal Nerve. This nerve lies close behind and to the inner side of the tendon of the biceps, and is exposed by an incision two or three inches long parallel to and close to the inner side of that tendon.

Anterior Crural Nerve. A longitudinal incision about two inches in length is made downward from Poupart's ligament, about an inch to the outer side of the femoral artery. The superficial circumflex iliac vessels will be divided; the nerve will be found close beneath the fascia.

NEUROTOMY.

I. *Primary Suture.* An incision is made in the course of the nerve, exposing it at the point of division. The ends are brought together by a couple of fine sutures of silk or catgut passed directly through the substance of the nerve or through the nerve sheath. They must be so placed and tied as not to strangle the fibres.

II. *Secondary Suture.* A long incision will probably be necessary; it should be made in the normal course of the nerve and extend well above and below the point of division. The trunk of the nerve should be sought for both above and below the cicatricial tissue of the original

wound, and traced downward and upward respectively to the divided and separated ends. Such part of each end as is bulbous or imbedded in cicatricial tissue should be cut away and the divided surfaces brought into apposition and sutured. Tension should be relieved by freeing the nerve above and below and by flexing adjoining joints.

It is not absolutely necessary to success that the divided ends should be brought close together; reunion has taken place across gaps of considerable length, one or two centimetres; it has been thought to be favored under such circumstances by the presence of a suture connecting the two ends.

When there has been a considerable loss of nerve substance, rendering it impossible to bring the divided ends near together, flaps have been cut from the proximal and distal stumps and unfolded, and their extremities united as in tenorrhaphy (Fig. 90); or the distal stump may be freshened and then inserted and sutured between the fibres of a neighboring uninjured nerve of similar, or at least partly similar, character.

TENOTOMY.

Professor Sayre,¹ in answering the question, How are we to determine whether, in any given case, we shall be compelled to resort to tenotomy? lays down the following rule as of universal application:

"Place the part contracted as nearly as possible in its normal position, by means of manual tension gradually applied, and then carefully retain it in that position; while the parts are thus placed upon the stretch, make additional point-pressure with the end of the finger upon the parts thus rendered tense, and if such additional pressure produces *reflex contractions*, that tendon, fascia, or muscle must be divided, and the point at which the reflex spasm is excited (the point at which the pressure is applied) is the point where the operation should be performed."

According to Prof. Sayre, the blade of a tenotomy knife should be one inch long, its shank one and three-quarters,

¹ Orthopedic Surgery and Diseases of the Joints. New York, 1876, p. 27.

its handle strong and marked in such a way that the surgeon can see at a glance in which direction the edge of the blade is turned. The blade may be straight or curved, it should be thick at the heel, very narrow, and the point should be somewhat rounded and sharpened from side to side like a wedge or chisel.

A fold of skin should be pinched up at the side of the tendon, and the knife entered at its base, so that a continuous track will not be left on its withdrawal. A preliminary puncture may be made with a sharp-pointed knife or lancet to facilitate the entry of the tenotome.

The knife must be entered "on the flat" and passed either under the tendon or between it and the skin; its edge is then turned toward the tendon and the division effected with gentle sawing movements, the thumb being pressed firmly against the tendon if the knife has been passed under it.

During the entry of the knife and the division of the tendon the latter must be kept firmly upon the stretch, and as soon as the division is complete the knife must be turned upon its side and withdrawn, while the surgeon follows its point with his thumb or finger so as to force out any blood that may be in its track and to prevent the entrance of air.

Seal the wound with plaster or collodion, and then bring the member into the desired position.

Tendo Achillis. The knife should be entered on the inner side of the tendon near its border, about one inch above the upper surface of the calcaneum. In this way the posterior tibial artery, which lies between the tendon and the inner malleolus and below the deep fascia, is secured from injury. The heel must be depressed as much as possible, so as to make the tendon more prominent and give additional security to the artery.

Tibialis Posterior. The tendon of this muscle may be divided (A) above the malleolus, or (B) on the side of the foot just behind its insertion into the scaphoid.

A. *Above the Malleolus.* The muscle is made tense by everting the foot; the knife is entered at the inner side of the tendon and passed behind it.

B. *On the Side of the Foot.* Same position given to the foot. The knife should be directed from above downward, and passed under the upper border of the tendon at a point half an inch below and in front of the tip of the malleolus. Bell¹ prefers to cut toward the bone.

Tibialis Anticus. Can be easily made prominent and isolated.

Peronei. May be divided at the posterior face of the lower end of the fibula, or on the side of the foot below and in front of the tip of the outer malleolus.

Flexor Tendons at the Knees. It must be remembered that the external popliteal nerve accompanies the tendon of the biceps closely, lying upon its inner side.

Sterno-cleido-mastoid. The danger to be avoided in this operation is that of injury to the external jugular vein at the outer border of the muscle, or to the anterior jugular vein at its inner border. The first can usually be seen under the skin and avoided, the other leaves the muscle about three-quarters of an inch above the sternum and passes backward. The muscle should be divided about half an inch above the top of the sternum, and most authorities agree in preferring to divide from before backward. The knife should be entered at the outer border of the muscle.

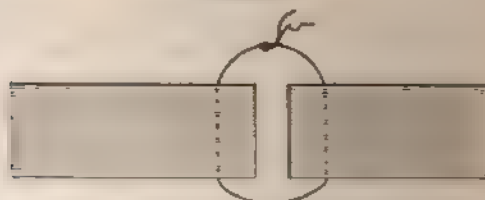
Levator Palpebræ. In a case of paralysis of the orbicularis palpebrarum followed by retraction of the levator palpebræ with inability to close the eye, and subsequent ulceration of the cornea, Professor Detmold divided the latter muscle at its attachment to the upper edge of the tarsal cartilage. The result was very good.

¹ Manual of Surgical Operations, 3d edition, p. 256.

TENORRHAPHY.

Primary. Performed immediately after the injury. Antiseptic precautions are especially necessary. The distal end of the tendon can usually be recognized in the wound without difficulty. The proximal end will sometimes retract several inches, especially if it was on the stretch at the time of the injury, and an extensive dissection and splitting of the sheath may be necessary to bring it within reach. The divided tendon ends are drawn into apposition and

FIG. 86.

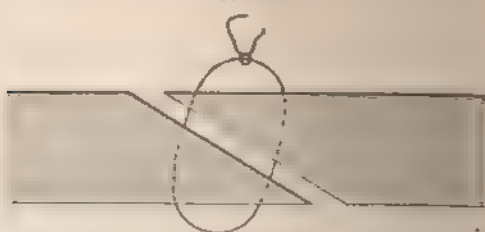


Tenorrhaphy by a suture passed through the substance of each segment

stitched together with fine silk, silkworm-gut, or catgut. The common forms of suture are represented in Figs. 86, 87, 88, 89.

If the divided surfaces cannot be brought into apposition and kept there without undue tension, one or both ends of

FIG. 87.

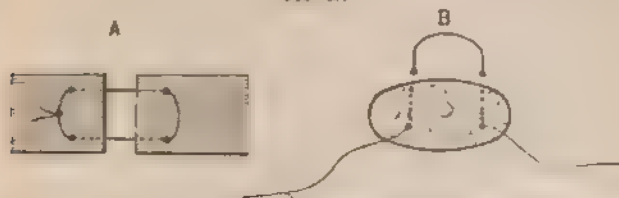


Tenorrhaphy The tendon ends cut obliquely to increase the surfaces in contact

the tendon may be split and turned down to lengthen it as indicated in Fig. 90, or the cut ends of the tendon sheath may be carefully sutured in hopes that union of the tendon

within may occur as after tenotomy performed by the surgeon. Another method is to draw the cut ends of the tendon together as much as possible by one or two catgut sutures, which are left in the gap to act as a nidus for new

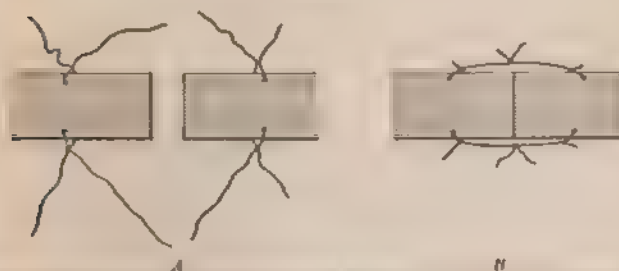
FIG. 88.



Tenorrhaphy. Showing the method of inserting a suture which does not readily pull out.

tendon tissues. Ingrafting of portions of tendon taken from another region or even another animal has been performed, and it is said successfully. (*Bulletin de la Soc. de Chir.*, 1886, p. 357.)

FIG. 89.



Tenorrhaphy by four ligatures inserted and tied A in each stump and their free ends then united (B).

In all cases of tenorrhaphy the tendon sheath when it exists must be preserved as far as possible. It is important to immobilize the limb during healing in the position of greatest relaxation of the sutured tendon.

Secondary. Performed after a considerable interval of time has elapsed since the injury. The divided tendon

ends will have to be sought for in a mass of cicatricial tissue and brought into the best possible apposition. The ends can be split and lengthened as already described; if

FIG. 90.



Tenorrhaphy by flaps to bridge over a gap between the tendon ends.

this will not do or the proximal end of the tendon cannot be found the distal end may be sutured to a neighboring tendon having the same general anatomical course.

The surface from which union is expected should be freshened by scraping.

MISCELLANEOUS OPERATIONS.

THIERSCH'S SKIN GRAFTING.

The wound to which the graft is to be applied must be fresh, clean, dry, and perfectly aseptic. If it is already a granulating surface all pus must be carefully washed away with a sterilized brush, soap and water, and the granulations freely shaved away with a knife. It is then thoroughly washed with a sterilized salt solution (about 5% of common salt to 100 of water). Bleeding is checked by the pressure of a sterilized compress maintained until the grafts are ready to be applied, in order to preserve the asepsis and to prevent the formation of clots of blood which would separate the graft from contact with the raw surface.

The graft is commonly taken from the front or outer surface of the thigh, as this presents a conveniently broad surface of skin of the requisite thickness. It must be previously shaved and scrubbed, then rinsed off with alcohol

and finally with sterilized water. The skin of the thigh is drawn tense and flat by one hand grasping the thigh just above the knee and pulling down. With the other hand a broad-bladed razor, ground flat on the surface held next the thigh, is drawn downward toward the knee by quick sawing motions through the skin parallel to and just beneath its surface. The cutting must be done with accuracy and the razor's edge must lie always in the papillary layer of the skin. Practically it must pass just deep enough to have the cut surface studded with minute specks of blood which do not coalesce for an appreciable length of time. If the knife exposes any particle of the subcutaneous fat the corresponding part of the intended graft must be rejected. The sterilized salt solution already mentioned is allowed to trickle on the skin immediately in front of the advancing razor-edge, and serves to float the graft up into the concavity on the anterior surface of the razor, and with a little practice facilitates the cutting. A strip six or eight inches long and one and a half or two inches wide can be cut and retained on a broad blade. The attached end of the graft is severed with scissors. The graft is then immediately unfolded on the prepared wound surface by retaining the whole width of the free end against one margin of the area to be covered, and gently withdrawing the razor while its edge is kept constantly in contact with the wound surface.

If any portions of the graft get turned over so as to oppose the epidermic layer to the wound surface, they must be carefully unfolded. In addition all air-bubbles must be pressed out toward the edges; and, in short, every part of the freshly cut papillary layer of the graft must be brought into accurate contact with the underlying raw surface which is to be covered.

Successive grafts are cut and applied until the entire surface is covered.

The grafts are then covered completely with strips of sterilized rubber tissue about an inch wide (after rinsing them in the sterilized salt solution), placed side by side with the edges slightly overlapping.

This arrangement permits drainage and allows the graft to be kept damp with the next applied sterilized com-

presses, wrung out in either the sterilized salt solution or a sterilized saturated solution of boric acid.

The compresses are covered with a sheet of sterilized rubber tissue to prevent drying. This dressing must be very carefully bandaged in place with even pressure and without disturbing the grafts. From time to time, till it is removed at the end of five days, it must be moistened with the sterilized salt or boric solution.

ERECTILE TUMORS.

The usual methods of treating erectile tumors are by the ligature, caustic, cautery, coagulating injections, electrolysis,

FIG. 91.



Subcutaneous ligature of nevus.

and excision. Physick cured one upon the finger by circumscribing it with a deep incision.

Ligatures should be so applied as to cut off the supply of blood entirely. Figs. 91, 92, 93, 94, and 95 represent good methods. The caustic treatment is applied to small naevi; nitric acid, or the acid nitrate of mercury, may be used. The actual cautery is applied by passing white-hot needles into or through the tumor; sometimes a very dis-

figuring scar results. Coagulating injections usually give good results, but the method is considered dangerous on

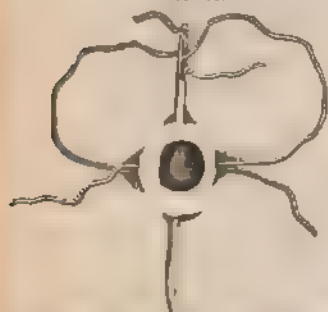
FIG. 97



Subcutaneous ligature of naevus. The needle passed under the tumor; one thread divided

account of the possibility that the coagulation may extend into the larger vessels, and give rise to embolism. The

FIG. 98.



The other end of the divided thread passed into the needle's eye, and the needle passed through at right angles to its former direction

FIG. 94



The needle removed and the naevus strangulated in quarters

solution, persulphate of iron, should be injected, three or four drops at a time, at several points by means of a hypodermic syringe; or the naevus may be incised longitudinally and the iron applied directly to the surface of section. If not too extensive the whole naevus should be dissected out and the hemorrhage controlled by pressure, ligation, or the actual cautery. The resulting gap is closed by a plastic operation or by Thiersch grafts. Electrolysis is applicable to a capillary naevus or birth-mark. The poles of a

battery are connected with a pair of fine platinum needles, which are plunged into the growth about a quarter of an

FIG. 90.



Ligature of large nerves. The white loops are divided on one side and the black on the other, and the corresponding ends A A' and B B' tied together.

inch apart, and a current of from 2 to 10 milliamperes thus passed. The punctures must be repeated all over the diseased area.

BIRTH-MARK.

Balmanno Squire¹ has introduced a very simple method of removing "Port-wine birth-marks." He freezes the spot with the ether spray and makes a number of fine parallel incisions from one-thirty-second to one-sixteenth of an inch apart, and extending about half through the skin, or at most to the depth of one-sixteenth of an inch. A piece of sterilized blotting paper is then laid over the incision and pressed steadily down upon the skin for five minutes, with just enough force not to cause the incision to gape. In twenty or thirty minutes the blotting paper must be thoroughly wet with a 1:5000 solution of bichloride of mercury and removed by pulling it in the direction of the cuts; the

¹ *Essays on the Treatment of Skin Diseases*, No. III. London, 1876.

underlying thin film of blood clot must also be gently and patiently washed off with a camel's-hair brush. If this is properly done no bleeding will occur and no scar will be left, while if the clot is not removed it is likely to cause suppuration and prevent primary union. In some cases it is necessary to make cross-markings at right angles to the first to effect a complete cure.

SEPARATION OF WEB-FINGERS.

Experience has shown that simple division of the membrane uniting the two fingers is insufficient, because reunion, beginning at the angle, is certain to extend over the whole length of the incision. A simple way of overcoming this difficulty is to pass a leaden or silver wire through a puncture made at the interdigital angle, keep it there until cicatrization has taken place around it, as around an ear-ring, and then divide the membrane. The angle being already cicatrized, the lateral wounds heal separately.

FIG. 96.



Web fingers.

Another plan is to mark out a palmar and a dorsal triangular flap at the interdigital angle, its apex turned toward the ends of the fingers Fig. 96, A, then to split the remainder of the membrane longitudinally, pare off the ends of the triangular flaps, and unite them in the interdigital

angle. By this means a bridge of integument is formed which prevents reunion of the sides.

These two methods answer very well when there is a distinct interdigital membrane, but some other is required when the fingers are closely approximated. The one which yields the best results is represented in Fig. 96, *B*, and Fig.

FIG. 97.



97. A rectangular flap is dissected up from the dorsum of one finger, and a similar flap from the palmar surface of the other finger, each being left adherent by its long side. The fingers are then separated and each flap turned in to cover one of the raw surfaces.

CICATRICAL FLEXION OF THE PHALANGES.

The cicatrix must be divided thoroughly to allow complete extension, and then if skin flaps can be obtained from the sides they may be turned in to cover the palmar surface opposite the joints. In dissecting up the flaps care must be taken not to go deeply enough to involve the artery which runs along the side, otherwise the ends of the finger may slough.

Instead of small lateral flaps for the flexures of the joint the skin covering the sides of the finger may be mobilized by lateral or dorsal longitudinal incisions and brought together in the median line of the palmar surface, the gap created on the sides by their removal being left to heal by granulation.

DUPUYTREN'S CONTRACTION OF THE FINGERS.

Open Method. A. A simple transverse incision is made through the skin and palmar fascia wherever the band is most prominent, and the gap covered with a Thiersch skin graft.

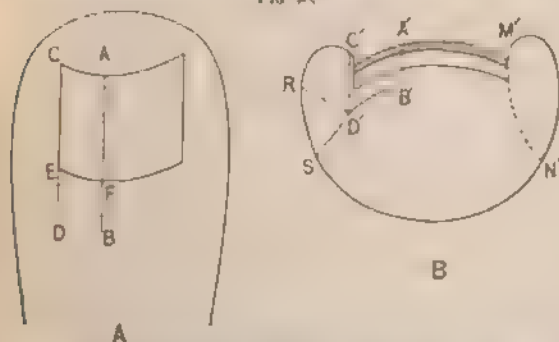
B. A longitudinal incision is made through the skin over the most prominent portion of the constricting band, and crossed at each end by a transverse incision. The flaps thus marked out are dissected up from the aponeurosis, which is then divided transversely or excised.

Resultant gaps in the skin should be closed by flaps or skin grafts.

INGROWN TOENAIL.

The base of the toe is constricted with a rubber tourniquet and a few minims of a 2 per cent. solution of cocaine injected on the sides and dorsum. The nail is then torn out (in all cases) with forceps, one blade of which is pushed up under it to free it from the matrix.

FIG. 98.



Ingrown toenail.

A. A, B, D, C, flap operation: parts removed shown in B. A', B' (C', D').
B. M', N', S, wedge operation: M', N' showing part removed by Cutting's operation.

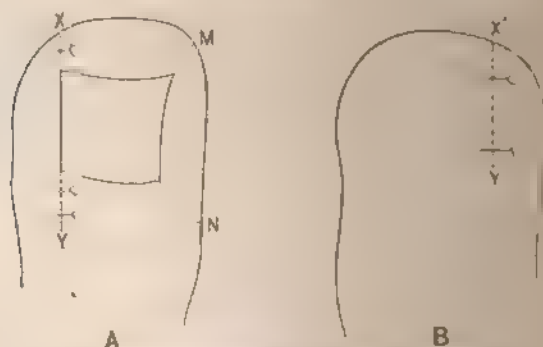
I. A rectangular flap, D, E, F, B (Fig 98, A), about one-quarter of an inch square, is made and the skin con-

tained in it reflected. The strip of matrix underlying it (Fig. 98 A, A, B, D, C), and the corresponding part of the nail in front, is then thoroughly dissected off, care being taken to carry the dissection entirely beyond the base and side. The flap is next replaced and secured and a light dry dressing applied.

II. The exuberant tissue and adjoining skin is pared off close up to the margin of the nail and matrix (M', N'). The resulting wound is left to close by granulation. (Cotting). (Fig. 98 B, M', N' and Fig. 99 A, M, N.)

III. In certain cases a wedge-shaped piece can be excised from the side of the toe, and by closing this gap with sutures the irritated part is drawn away from the nail (R, S, D', Fig. 98 B).

FIG. 99



A. X, Y, Anger's method. M, N, Cotting's method.
B. X', Y', Anger's method viewed from underneath.

IV. *Anger's Method.*¹ With every antiseptic precaution the nail is split longitudinally in the middle and the nail on the diseased side torn out. A knife is then made to transfix the toe vertically from beneath the overhanging fold of skin at the posterior angle of the exposed matrix and is carried straight forward along the side of the pedicel through all the tissues, closely following the lateral border of the matrix.

¹ Du et Micro de nos de Chir de Paris, 1899, p. 604. Also New York Medical Record, September 2, 1898, p. 299.

The flap is turned back and the exposed granulation and epidermic tissue is ablated, and the uncovered matrix very thoroughly excised up to the split edge of the nail. The flap is then replaced and sutured, and the wound dressed antiseptically.

THE OPERATIVE TREATMENT OF DISEASED CERVICAL GLANDS.

The operations required in the treatment of diseased cervical glands comprise opening abscesses, scraping and slitting up sinuses, and partial or complete removal of the enlarged lymph nodes. When the latter have not become broken down and matted together into an indistinct mass by inflammatory processes—in other words, when the glands can be felt as rounded, more or less movable tumors, each will be found enclosed in a distinct capsule, which, if once opened, permits of the gland being readily “shelled out” with a Volkmann spoon. There remains only a small pedicle of vessels to be secured at the base of the node.

Removal is ordinarily accomplished through a more or less longitudinal incision which follows the general direction of the underlying structures, and is placed over the most prominent part of the tumefaction. This is generally along the anterior or posterior border of the sternomastoid muscle; occasionally it may be necessary to make it along nearly the whole length of both borders to obtain sufficiently free access to all the glands. The incision must be long enough to give a clear view of each structure as it is encountered, and to permit of ready control of the hemorrhage.

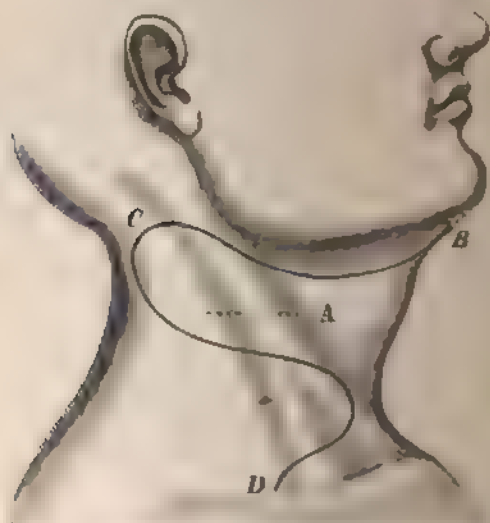
The difficulties attending a thorough removal of all diseased parts by even a double longitudinal incision are so great that Dr. Hartley, of New York,¹ has devised an operation in which cutaneous flaps are raised from the surface of the tumor. At first sight it appears unnecessarily severe, but the results hitherto have been excellent, and the scarring is not so noticeable as to offset the great advan-

¹ This description has been revised by Dr. Hartley, who expects to publish his method with a report of cases.

tages gained by a complete exposure of all the important parts which are in close relationship with the enlarged glands.

The incision is S-shaped (Fig. 100, *B, C, D*), and involves only the skin, subcutaneous tissue, and fascia: starting below the chin it passes in a curve downward and backward to

FIG. 100.



B, C, D Hartley's incision for the removal of enlarged cervical glands.
A Point where the sternomastoid is divided.

the hyoid bone, then up behind the angle of the jaw to near the lobule of the ear, whence it sweeps down along the anterior border of the trapezius, forward over the sternomastoid, and downward and backward again to terminate above the middle of the clavicle. (Fig. 100). The flaps thus formed are dissected up, exposing nearly the whole length of the sternomastoid, and the latter cut transversely near its centre and the ends reflected, care being taken not to injure the spinal accessory nerve above. The point where the muscle is divided must not be in the line of the

cutaneous incision, but under the middle of one of the flaps, preferably the upper. (Fig. 100, *A*). The great vessels are thus exposed from the mastoid process to the clavicle, and the operator can excise the adherent and diseased glands and avoid injury to the adjacent important structures.

At the close of the operation the divided ends of the sterno-mastoid are united with catgut, the flaps replaced and loosely sutured in position, and drainage provided for in the most dependent angles.

This large incision is only used when the glands in the superior and inferior carotid and submaxillary triangles are involved simultaneously. For less extensive disease the upper or lower flap may be employed alone, or one may be fashioned with a pedicle in a position the reverse of that shown in the figure. The incision for a single flap should approximately correspond to the circumference of the tumor, which is then exposed in its entirety by division of the sterno-mastoid below the joint where it is entered by the spinal accessory nerve. The flap consists of skin, subcutaneous tissue, platysma, and fascia, and after reflecting it the muscle is always cut beneath the centre of the flap, and not in the line of the cutaneous incision.

OSTEOTOMY.

Osteotomy of the Femur—

I. *Through the Neck* (Adams's operation), described on page 151.

II. *Below the Great Trochanter* (Gaut's operation), described on page 151.

III. *Osteotomy of the Shaft of the Femur.*

In a normal femur the epiphyseal line is about on a level with the tubercle of the adductor magnus and horizontal in direction. But in cases of genu valgum it is oblique and parallel with the articular surface. This is due to the fact that genu valgum is produced by an overgrowth of the diaphysis of the femur and not of the epiphysis (Fig. 101).

Osteotomy of the Shaft of the Femur from the Outer Side.
The knee is partially flexed and supported on a sand-bag

beneath its inner surface. A longitudinal incision down to the bone is made on the outer aspect of the thigh about two inches above the top of the external condyle and in front of the tendon of the biceps. The osteotome is introduced, is turned at right angles to the long axis of the femur, and is driven with short strokes of the mallet at

FIG. 101.



Vertical section through the lower end of the femur in a case of severe genu valgum.

- A. Epiphyseal line. B. Transverse line drawn through the adductor tubercle.
C. Line of bone section in MacEwen's operation.

least two-thirds through the bone, or far enough to render it easy for the operator to complete the division of the bone by fracturing it. This must be done cautiously, to avoid splintering, by first freely extending the knee and then adducting the leg, while counter pressure is made against the inner surface of the thigh; after each stroke of the mallet the chisel is loosened but not withdrawn. At the conclusion of the operation the wound is closed and dressed antiseptically, and the limb is immobilized in the corrected—straight—position.

MacEwen's Supra-condylar Osteotomy of the Femur. The hip and knee are flexed, and the thigh supported on its

outer side. A longitudinal incision about one inch long is carried down to the bone on the inner surface of the thigh. It should be one-half an inch anterior to the tendon of the adductor magnus, and with its centre on a line drawn transversely a finger's breadth above the top of the external condyle.

Before the knife is withdrawn the osteotome is slipped in by its side until it touches the bone. Its cutting edge is then turned at right angles to the long axis of the thigh, but without using pressure enough to tear off the periosteum, with which it is kept in contact. The edge is passed over the inner surface of the bone until it reaches the posterior internal border, and is then driven from behind forward and toward the outer side. The internal surface is next divided, and after this the chisel is directed from before backward and toward the outer posterior angle of the femur. This definite order of procedure leaves the operator certain of what has been divided and what is still to be done. The osteotome is not withdrawn till all the bone has been cut through except a thin shell on the outer surface of the femur. This is snapped or bent by adducting the leg, while counter pressure is made with the hand at the point of incision. The wound needs no sutures or drainage, and is simply dressed antiseptically and immobilized in the straight position.

IV. *Ogston's Operation* (division of the internal condyle). The point of a narrow-bladed knife is entered in the centre of the inner surface of the thigh about two inches above the adductor tubercle. With the edge directed toward the bone it is passed downward and outward over the inner and anterior surface of the femur till the groove between the front of the condyles is reached, and the joint opened. The cutaneous opening on the inner surface of the thigh is made large enough to admit a fine saw, and the junction of the internal condyle with the femur is sawn through obliquely. Many surgeons now prefer to use the chisel instead of the saw.

By adducting the leg the loosened condyle is displaced upward on the femur, and the genu valgum thus corrected.

This operation has been largely superseded by transverse division of the shaft above the condyles.

FIG. 102.



FIG. 103.



OSTEOTOMY FOR BENT TIBIA.

A longitudinal incision is carried down to the bone ~~over~~ its inner surface at the point where the abnormal curvature is most marked. At this point the bone is chiselled through transversely, partially or completely.

The fibula usually does not need division. The operation is completed by forcibly straightening the leg. In extreme cases a wedge-shaped piece of bone may have to be removed. Its base will usually correspond to the crest of the tibia.

OSTEOTOMY FOR HALLUX VALGUS.

A longitudinal incision about half an inch in extent is carried down to the periosteum on the inner surface of the first metatarsal bone. It should be placed so that a narrow bladed osteotome can divide transversely the shaft of the bone just posterior to the enlarged digital extremity.

The toe is then forcibly brought inward into line with its metatarsal bone. But this simple division of the bone will rarely be found sufficient. It is more often necessary to remove about a quarter of an inch of the shaft at this point. Then the digital extremity can turn on the transverse metatarsal ligament as a radius, and the end of the toe is brought much further inward.

The operation of incision of the metatarso-phalangeal joint for this deformity should be condemned.

CUNEIFORM OSTEOTOMY FOR TALIPES EQUINO-VARUS.

A horizontal incision is made along the outer side of the foot from about the centre of the anterior portion of the outer surface of the os calcis across the cuboid to the base of the fifth metatarsal bone. If necessary this is joined at its centre by a liberating incision passing perpendicularly to the horizontal incision across the outer surface and dorsum of the foot to or over the scaphoid.

The base of the wedge of bone to be removed will consist mainly of the cuboid with portions of the os calcis, the astragalus, and perhaps a part of the external cuneiform and base of the fifth metatarsal. The apex will correspond to a point on the inner surface of the scaphoid. The amount of bone which may need removal will of course depend upon the extent of the deformity, but in extreme cases it may include portions of all the tarsal and some of the metatarsal bones. In every case the cuboid will form a large proportion of the wedge.

With a blunt periosteal elevator all the soft parts are detached from the bone that is to be removed; the peronei tendons are retracted or protected; a thin blunt elevator may be pushed close under the plantar surface of the bones to protect the soft parts of the sole. The chisel is then driven in for the first bone cut, generally at the anterior end of the outer surface of the cuboid. It is directed toward the lower part of the scaphoid tubercle. The second line of bony division will usually need to pass just behind the anterior articular surface of the os calcis and through the neck of the astragalus to meet the first incision at the sca-

phoid tubercle. This wedge of bone is then pried or wrenched out entire, while any remaining attachments beneath are severed with blunt-pointed scissors or a knife kept close to the bone. If then it is found that the foot cannot be made to assume the proper position without tension another slice of bone is chiselled off, especially toward the apex of the wedge. This may be supplemented by tenotomy of any resisting tendons. The thickened epidermis and the bursa usually found over the site of the cuboid can be excised if there is found to be a redundancy of skin after straightening the foot.

No wiring of the bones is necessary. The soft parts are sutured and the wound dressed antiseptically. Any oozing which may subsequently occur will dry and make of a simple antiseptic dressing a very useful splint.

Of the great number of other operative procedures which may be used singly or in combination with each other or with cuneiform osteotomy for correcting pes varus or equinovarus mention should be made of tenotomy of resisting tendons (*q. v.*), extirpation of the astragalus (*q. v.*), extirpation of the cuboid or of several tarsal bones simultaneously, linear osteotomy of the tibia and fibula just above ankle-joint (*q. v.*), excision of a portion of the shaft of the fibula near the base of the external malleolus, followed by forcible abduction of the foot,¹ and Phelps's² operation. The latter, although not an osteotomy, will be described here.³

It is extensively used for remedying talipes equino-varus, and consists in a simple division of all structures which resist correction of the deformity. The tendo Achillis is first divided subcutaneously; then, while the foot is flexed dorsally, abducted and everted, an incision through the skin is made from just in front of the internal malleolus vertically downward across the inner third of the sole of the foot. After making the parts tense the tibialis anticus and posticus, the deltoid ligament, part of the abductor pollicis, the plantar fascia, and the flexor brevis and longus digito-

¹ Hopkins. *Annals of Surgery*, April 1895, p. 461.

² New Eng. and Mass. Med. J. N. 8, 1894.

³ This excellent operation is discussed and the results detailed in *Transactions Am. Orthopedic Assoc.*, vol. vii, p. 43.

rum are severed as encountered in the wound. The plantar vessels and nerves are spared if possible, although their internal branches have been cut without bad effect.

As each structure is divided an attempt is made to forcibly place the foot in its proper position. Phelps employs a powerful system of levers, and ruptures any resisting ligamentary or fibrous bands. When all opposition has been properly overcome the anterior segment of the foot can be bent backward in overcorrection, thus probably opening the astragalo-scaploid and calcaneo-cuboid joints. Only in about 10 per cent. of all cases, according to the originator of this operation, will osteotomy be required. When necessary to correct the deformity after all the resisting soft parts have been cut, the neck of the astragalus should be divided from the inside; then, if this is insufficient, a wedge may be removed from the anterior portion of the os calcis; the base of the wedge lies externally, the apex where the neck of the astragalus has been divided. The open wound on the inner side of the foot is either lightly packed with iodoform gauze or allowed to heal under a moist blood clot; over this an antiseptic dressing is applied and encased in plaster of Paris, the foot being maintained in a slightly overcorrected position.

CUNEIFORM OSTECTOMY FOR TALIPES EQUINUS.

Two horizontal incisions are employed.

The inner incision passes along the internal surface of the neck of the astragalus and across the scaphoid to terminate at the internal cuneiform bone. The external incision extends from the middle of the anterior portion of the outer surface of the os calcis across the cuboid to terminate at the base of the fifth metatarsal bone. The soft parts are raised from the dorsum of the foot, and a flat periosteal elevator can be passed close beneath the plantar surface of the bones to protect the soft parts of the sole. A wedge is then cut from the tarsal bones with the base on the dorsum of the foot. Its extent will depend on the degree of the deformity, but the apex must reach to the plantar surface of the bones. A metacarpal saw or chisel can be used.

The wedge, which may be extracted in one piece, will consist chiefly of the scaphoid and cuboid bones, with perhaps portions of the anterior extremities of the astragalus and os calcis. At the close of the operation the soft parts which have been divided are sutured and the foot immobilized with the bones in apposition.

CUNEIFORM OSTECTOMY FOR TALIPES VALGUS.

An incision is begun just below the apex of the internal malleolus and carried forward two inches. The soft parts are carefully raised from the inner and under surface of the astragalus and a suitable wedge removed from it. The base of the wedge should lie below and include either the neck alone of the astragalus or the articular surfaces of the astragalus and scaphoid.

OPERATIONS FOR UNUNITED FRACTURE.

The aim of the operative treatment for old ununited fracture is to place the freshened ends of the bone in contact and to keep them immobilized in this position.

A free incision is necessary. In general it should be in the long axis of the limb, and so placed as to reach the point of fracture by the shortest route with the least possible damage to nerves and vessels. Any tissue which may be found intervening between the ends of the bone is dissected out and removed. It will often be found advantageous to protrude the ends of the bone through the wound. The extremity of each fragment is then pared off with the rongeur or chisel till fresh cancellous tissue is exposed over the whole section of the shaft. If the fragments override, enough bone is removed to allow the ends to be easily brought into apposition. In such cases the exposed ends of the bones are sometimes dovetailed into each other or sawn off in such a manner as to bring large surfaces in contact. Then nails or pegs are driven in at right angles to the shaft. If these latter are employed there is a great probability of suppuration, with more or

less necrosis, and they should always be placed with a view to their early subsequent removal. Wiring is to be condemned as superfluous. It will seldom be found necessary to do more than freshen the ends of bone and maintain them in quiet apposition with a suitable splint. If there is the least doubt about their remaining in this position while the splint is applied and subsequently, it is better to drill a small hole about half an inch from the fracture line on each side and tie the ends together with a piece of kangaroo-tendon or stout chromicized catgut. This of course has no great strength, but if the limb is handled carefully it will keep the bones in contact and prevent the interposition of soft parts till the limb has been immobilized. In addition to this the periosteum is as far as possible preserved, and any divided soft parts in the neighborhood should be placed in proper position and reunited. This will serve as a sling for the bones to rest in. The wound is then closed layer by layer and dressed antiseptically, with provision for temporary drainage. If pegs or nails have been used they should reach to the skin surface and be included in the dressings.

SUTURE OF THE PATELLA.

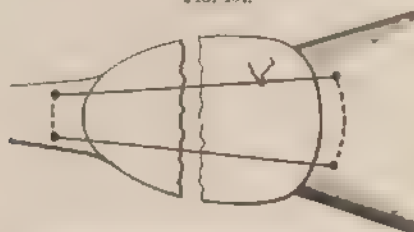
I. Open Method.

Every antiseptic precaution is necessary. A median longitudinal incision is made about three inches in extent, its centre opposite the point of fracture. Everything is divided down to the bone. Any bloody effusion or coagulum between the fragments is simply pressed out, and nothing is introduced into the interior of the joint. Interposed fibrous and periosteal shreds are cleared away. The bone is drilled in the median line on each side of the point of fracture. Both holes are oblique and start on the anterior surface of the bone half an inch from the edge of the fracture. They should terminate opposite each other in the fractured surface close to but not including the articular cartilage.

The fresh surfaces of bone are then brought into accurate contact by a silver wire passed through the drill holes. The

wire is cut short and the ends hammered into the bone or left to protrude from the wound, to be subsequently withdrawn. A better procedure is to use silk or silkworm-gut instead of wire. The skin wound is then closed and dressed antiseptically and the leg immobilized by a plaster-of-Paris splint.

FIG. 104.



Mediate suture for fracture of the patella

II. *Mediate Silk Suture* (Fig. 104).

This may be done with cocaine anaesthesia, but the chance of infection is somewhat increased thereby. A longitudinal median incision is made extending well above and below the fragments. Clots are removed from the joint and the fibro-periosteal fringe lifted up if one has been found. Then, with a full-curved needle, a stout silk ligature is passed transversely through the ligamentum patellae close to the apex of the patella, then transversely in the opposite direction through the tendon of the quadriceps close to its insertion, and then drawn tight and tied while the fragments are held together. The incision is then closed without drainage.

Many other more or less complicated methods of holding the fragments together have been devised; this one seems to be as simple as any, and has proved to be efficient and safe in more than fifty personal cases.

OPERATION FOR NON-UNION AFTER FRACTURE OF THE OLECRANON PROCESS.

A median longitudinal incision is made over the posterior surface of the olecranon and ulna, exposing the bone at the

point of fracture. The interposed fibrous tissue is cleared away and the ends of the fragments freshened. The olecranon and ulna are drilled obliquely without perforating the articular surface. The holes start on the posterior surface about one-quarter of an inch from the edge of the fracture and terminate in the fractured surface.

The fragments are drawn together with a silk suture or silver wire, as in the patella, and the limb immobilized by an antiseptic dressing in complete extension.

Mediate suture, with silk passed through the tendon of the triceps and a hole drilled transversely through the shaft of the ulna half an inch or more below the fracture, is probably to be preferred to direct suturing.

LAMINECTOMY.¹

An incision five or six inches long is made in the median line over the summit of the spinous processes in question, and quickly deepened close to one side of them till the laminae are exposed, from which the periosteum with the attached muscles is raised with an elevator out to the articular and transverse processes. The bases of the spinous processes are next cut through with a chisel or bone forceps, and the opposite laminae freed in the same way of periosteum and muscle, without disturbing the muscular attachments of the spinous processes.

Some operators prefer to make two parallel incisions on each side of the spinous processes, which are then excised, and Horsley, to better expose the laminae, divides the lumbar aponeurosis and muscles at right angles to the middle of the longitudinal incisions. The sides of the wound are well retracted and the laminae are divided close to the transverse processes with a rongeur, bone forceps, or chisel, and the posterior arch thus removed.

If the trouble is not then apparent before opening the dura a probe should be passed up and down to make sure that the cord has been exposed in the proper locality. If,

¹ Thorburn *Surg. of Spin. Cord*, Lloyd, *Amer Journ. Med. Sciences*, 1891, vol. 102, p. 25.

then, it is considered necessary, the dura is pinched up and opened longitudinally in the median line behind.

Subsequently the wound in the dura is closed with fine catgut or silk sutures and the overlying parts brought together by buried and superficial sutures over a drainage-tube placed in the deepest portion of the wound.

PART VI.

PLASTIC OPERATIONS ON THE FACE.

PLASTIC operations are required for the relief of congenital defects or for the restoration of parts lost by disease or injury. The methods most commonly employed are of two kinds:

1. *By Approximation of the Edges.* This is applicable to cases in which the loss of tissue is not great and the adjoining parts are supple. The edges of the gap are simply pared and brought together. It is sometimes necessary to make "liberating incisions" on one or both sides for the relief of tension.

2. *By Transfer of a Flap.* A flap of suitable shape and size is dissected up and transferred, by turning it about its base, to the place where it is needed, its vitality being insured by the preservation of its base or pedicle. This method admits of a great variety of modifications in its details, from a simple sliding of a skin flap, which differs but slightly from the method by approximation, to the transfer of skin, muscle, and bone, or the taking of the flap from another limb or individual.

The names *Indian*, *Italian*, *French*, and *German methods* have been given to the different varieties, but Verneuil¹ has pointed out the impropriety of continuing to employ them, especially since at least two of them, the *French* and *German*, have their origin in an oversensitive patriotism not mindful enough of the actual facts. The *Indian* and *Italian methods* were first employed for the restoration of the nose; in the former a flap was taken from the forehead and brought down by twisting the pedicle which occupied the space be-

¹ *Mémoires de Chirurgie*, vol. 1. *Chirurgie Réparatrice*, p. 401.

tween the eyebrows. The term is now applied to any operation in which the flap is made with a long pedicle situated at some distance from the space which the flap is to cover, and in which the flap is brought into place by rotation over a greater or less arc described about the base of the pedicle as a centre (see Fig. 120).

In the *Italian method* the flap is taken from a distant part of the body, as in restoration of the nose by a flap taken from the arm (Fig. 125). Tagliacozzi, of Bologna, the originator of this method, allowed the flap to suppurate for a few days, so as to increase its thickness, before fastening it in its new situation. Arnææ sought for primary union, and gave, rather pompously, the name *German method* to this modification, ignorant of the fact that it had been suggested more than a century before by Reneaulme de la Caramie, and unmindful of the other fact that it contained no new principle, and must have been entertained by Tagliacozzi, and only rejected for the sake of another advantage decomposition with it.

In the so-called *French method*, the principles of which are found in Celsus, the flap has a broad base, and is brought into place, not by rotation, but by traction in the direction of its axis (Figs. 110 and 128). The variations and combinations of these methods are now so numerous that the names no longer have much descriptive value.

General Principles. The edges of the flaps must be brought together without tension, and united very accurately by means of fine silk, catgut, or silver sutures; and it is well to cut the edges obliquely so as to have a broader surface of contact as proposed, I believe, by Dr. Packard.

Haemorrhage must cease before the flaps are brought into place. The presence of a clot of blood under a transplanted flap is one of the most common causes of failure.

Flaps must be taken from healthy non-cicatricial skin, and vascularized as far as they can, and not very vascular the subcutaneous layer should be taken with it to insure its vitality.

The base of a flap should occupy the quarter from which the flap proper is taken, and the direction and shape of the flap should be such that it can be brought into place with the least amount of twisting of the base.

The flap should be made considerably larger than the space it is to fill, and, to insure accuracy, it is well to cut it according to a pattern previously made of paper or oil silk. It is well also to mark the angles by fine pins planted erect in the skin.

The raw surface left by the dissection of a flap may be partly covered by drawing its edges together with sutures; the remainder must be left to granulate or may be covered by Thiersch grafting. Dr. Gurdon Buck¹ recommended a dressing for it which he calls the "collodion crust;" it is made by covering the surface with dry scraped lint, and then with an additional layer of lint saturated with collodion.

Every antiseptic precaution is necessary to prevent or diminish suppuration, and thereby restrict the formation of cicatricial tissue. If strict asepsis is observed greater tension can be made with the sutures than would otherwise be safe, and the chances of failure or of the occurrence of erysipelas, for instance, become less.

CHEILOPLASTY.

A. Lower Lip. Restoration of the lower lip is usually undertaken to make good the loss of substance occasioned by the removal of an epithelial tumor. The choice of a method depends upon the extent of the disease.

1. **V-Incision** (Fig. 105). When the tumor is small, involving not more than one-quarter or one-third of the lip, it may be removed by a V-incision, and the sides of the gap brought together with one or two points of twisted suture. The mucous membrane on the inside of the lip should be excised to the same extent as the skin, although it is not usually involved in the disease. If not removed it forms a disagreeable fold or pucker in the lip.

The hardlip pins must be deeply placed, passing close to the mucous membrane on the inside. This insures confrontation of the raw surfaces throughout their entire breadth, and the pressure of the twisted sutures prevents hemorrhage.

¹ Reporative Surgery, 1876, p. 13.

2. *Oval Horizontal Incision* (Fig. 106). When the tumor covers a considerable extent of surface, but does not pene-

FIG. 105.



Cheiloplasty, V-incision.

trate deeply, it may be safely excised by cutting under it with curved scissors. The mucous membrane and skin

FIG. 106.

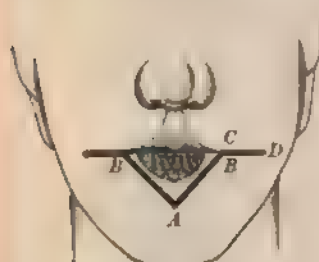


Oval horizontal incision.

may then be stitched together, or the wound allowed to heal by granulation.

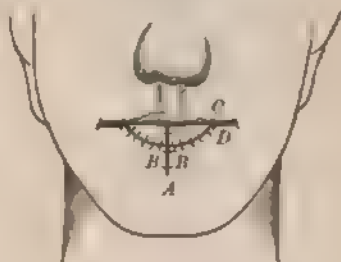
3. *Method of Celsus or Serres* (Figs. 107 and 108). The V-incision is supplemented by a horizontal one on each side carried outward from the angle of the mouth for about two inches, and comprising the whole thickness of the cheek for

FIG. 107.



Cheiloplasty. Celsus's incisions.

FIG. 108.



Cheiloplasty. Celsus's flaps in place.

the first two-thirds of its length, but dividing the mucous membrane at a somewhat higher level than the skin. The lower gingivo-labial fold is divided close to the gum on both sides, and the dissection carried downward close to the periosteum, and backward toward the angle of the jaw until

FIG. 109.



Cheiloplasty. Dieffenbach's method

the edges of the gap in the lip can be brought together without tension. The sides of the V are then brought together, and the lip formed from the lower parts of the horizontal incisions (Fig. 108). The mucous membrane and skin are stitched together along the edge of the new lip, and the remaining portion of the lower flap on each

side (that which remains external to the new angle of the mouth) is reunited to the upper flap. The mucous membrane at the outer end of the horizontal incision is stitched to the skin and covers the angle.

4. *Dieffenbach* (Fig. 109) adds a vertical incision at the end of each horizontal one, thus marking out two quadrilateral flaps which are brought together in the median line. The gaps left in the cheek by the transfer are allowed to close by granulation.

FIG. 110.



Syme-Buchanan incisions.

FIG. 111.



Syme-Buchanan flaps in place.

5. *Syme-Buchanan* (Figs. 110 and 111). The method by latero-inferior flaps is ascribed by some to Syme, by others to Buchanan, of Glasgow.

After the tumor has been removed by the usual V-incision, the incisions are prolonged downward and outward for nearly an inch, and then curved upward and outward. These flaps are dissected off the bone and brought together in the median line. The mucous membrane and skin are stitched together along the upper edge, the gaps left by the shifting of the flaps drawn together as much as possible, and the remainder left to heal by granulation.

Rankin and Trélat (Figs. 112 and 113) make the flap on one side longer, and lift it over the other to form the new lip, the shorter flap being used as a support for the former.

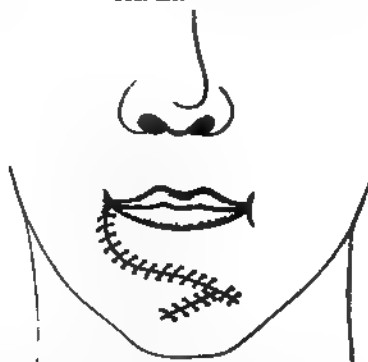
6. *Buck's Method* (Figs. 114 and 115). Buck preferred to make two operations. He first removed the tumor by the V-incision, brought the sides of the gap together, and allowed them to unite. After the union had become com-

plete he restored the angle of the mouth and lengthened the lower lip with material taken from the upper one by the following method :¹

FIG. 112.

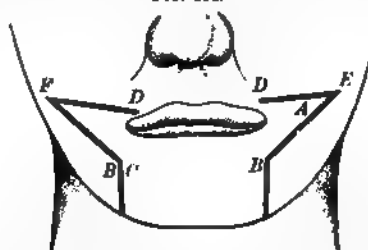


FIG. 113.



In Fig. 108, *B B* represent two pins inserted a finger's breadth below the under lip border, one on either side of the chin, a little to the outside of the angle of the mouth, and equidistant from the median line; *D D* are also two pins inserted, one on either side, into the upper lip at the

FIG. 114.



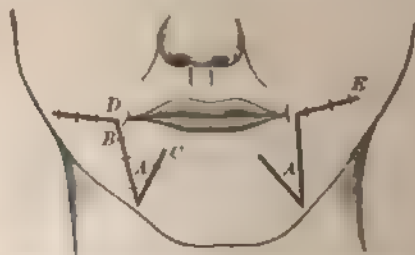
Restoration of lower lip. Buck's Incisions.

margin of the vermillion border, equidistant from the median line, and at such distance apart as to include between them sufficient length of lip border for a new upper lip.

¹ *Reparative Surgery*, 1876, p. 22 et seq.

The steps of the operation are then the following: With the forefinger of the left hand placed on the inside of the mouth, the left cheek is to be kept moderately on the stretch, while it is transfixed with a sharp knife at the point *B*. An incision is then carried through the entire thickness of the cheek, upward and a little outward, a distance of one inch and a half to a point, *E*, near the middle of the cheek. The corresponding side of the upper lip should next be

FIG. 114.



Restoration of the lower lip. Buck's flap in place.

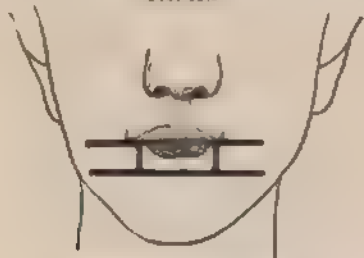
transfixed at the point *D*, and the incision carried through the lip and cheek outward and a little upward to join the first incision at *E*.

The next step is to transfer the triangular patch, thus marked out, from the cheek to the side of the chin. For this purpose an incision should be made on the side of the chin from *B* vertically downward to the edge of the lip and to the depth of the periosteum. The edges of this incision, retracting wide apart, afford a V-shaped space for the lodgment of the triangular patch, which is now brought around edgewise, and adjusted by sutures in its new position (see Fig. 115). The gap left in the cheek is closed by bringing its edges together and securing them in contact by sutures. By this adjustment a new and naturally shaped angle is formed for the mouth at the point *D*. The incisions should be made with the utmost precision, and special care should be taken that the lining mucous membrane is divided exactly to the same extent as the skin.

The same procedure may be applied to the other side of the mouth, and executed at the same operation.

7. *Square Lateral Flaps*, Malgaigne (Fig. 116). The tumor is circumscribed by two vertical incisions carried downward from the edge of the lip, and a third horizontal

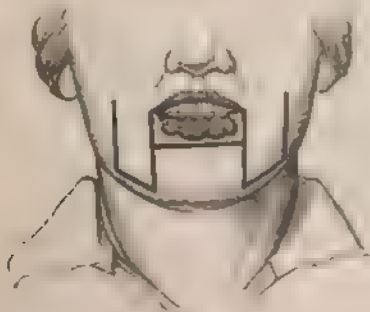
FIG. 116.



Cheloplasty. Malgaigne.

one uniting the lower ends of the first two. To fill the square gap thus created, two horizontal incisions are made on each side—one from the angle of the mouth, the other from the lower corner of the gap. The flaps circumscribed by these incisions are brought forward and united in the median line, and the mucous membrane stitched to the skin along the edge of the lip and at the commissures. (See also 3. *Method of Celsus*, p. 265, and *Stomatoplasty*, v. inf.)

FIG. 117.



Cheloplasty Sédillot.

8. *Square Vertical Flaps* (Fig. 117). Sédillot made the flap at right angles to the line of the mouth. The incisions

are shown in Fig. 117. Each flap is swung around to meet the other in the median line, its inner vertical border becoming the edge of the lip.

B. Angle of the Mouth (Stomatoplasty). An attempt to restore a large portion of either lip by means of material taken from the other, or to close a gap by simple approximation, not infrequently leaves the mouth small, rounded and pouting, with obliteration of one or both angles. This defect can be overcome by the operation described (p. 266) as Buck's method of restoration of the lower lip, or by extending the mouth laterally by a horizontal incision involving both skin and mucous membrane, and then preventing reunion by stitching the skin and mucous membrane together on both sides and at the angle of the incision. Sillitot considers it indispensable to excise a portion of the skin so as to have a comparative excess of mucous membrane, which when stitched to the skin will roll outward and form a vermilion border. This simple method has been modified by Dr. Buck as follows:

Buck's Operation¹ for Enlargement of the Mouth and Restoration of its Angle. (Fig. 118.) An incision is made with great exactness along the line of the vermilion border, circumscribing the circular half of the mouth, and extending to an equal distance on the upper and lower lips (a, b, c). This incision should only divide the skin, without involving the mucous membrane. A sharp-pointed, double-edged knife should then be inserted at the middle of this circular incision, and directed flatwise toward the cheek, between the skin and mucous membrane, so as to separate them from each other as far as the new angle of the mouth requires to be extended. The skin alone is next divided from the commissure of the mouth outward toward the cheek. The underlying mucous membrane is then divided in the same line, but not so far outward. The angles at the outer ends of the two incisions are then accurately united by a single thread suture. The fresh-cut edges of skin and mucous membrane above and below, that are to form

¹ Reparatve Surgery, p. 264 et seq.

new lip borders, are shaped by paring first the skin and then the mucous membrane in such a manner that the latter

FIG. 118.



Lengthening of the mouth. Buck.

shall overlap the former, after they have been secured together by fine thread sutures inserted at short intervals.

FIG. 119.



Cheiloplasty of upper lip. Sedillot.

FIG. 120.



Sedillot. Flaps in place.

C. Upper Lip. The V-incision and the oval horizontal incision (p. 264) may be used when the loss of tissue will

be small. Also the square lateral flaps (p. 269) when the gap to be filled is in the centre of the lip and rather large.

1. *Vertical Flaps* (Figs. 119 and 120). These may be made with the base directed upward (Sédillot) or downward (Chauvel). Chauvel claims that the latter method is to be preferred because the retraction of the cicatrix in the former tends to draw the new lip upward and expose the teeth.

The flaps comprise the entire thickness of the cheek, are turned inward at right angles to their former position and united in the median line. The gaps left in the cheek by their removal are brought together with sutures or left to granulate.

2. *Infero-lateral Flap* (Buck). Fig. 121. For loss of the right half of the upper lip Dr. Buck employed the following method, enlarging the mouth afterward and re-establishing the angle by the method described above (p. 270).

FIG. 121.



Repair of upper lip by infero-lateral flap. Buck.

The extremity of the under lip, where it joined the right cheek, was divided through its entire thickness at right angles to its border, and the division carried to the extent of one inch from the border (*a* to *b*, Fig. 121). A second incision was made from the terminus of the first parallel

the lip border for a distance of one inch and a half toward the chin, *b* to *c*. The quadrilateral flap thus formed from the under lip was folded edgewise upon itself, and made to meet the remaining half of the upper lip, and be adjusted to it by its free extremity. In order, however, to make this fold, the under lip had first to be divided obliquely half across its base, *c* to *d*.

The left half of the upper lip was prepared for the new adjustment by dividing the buccal mucous membrane close to the jaw and detaching the parts above toward the orbit from the underlying periosteum, and secondly by paring a strip of vermilion border from the extremity of the half-lip of sufficient length to permit the end of the half-lip to be matched to the free extremity of the under-lip flap. The parts concerned having been thus prepared, the under-lip flap was doubled edgewise upon itself, and its free extremity adjusted to the half of the upper lip, and the two secured to each other in a vertical line below the *columna nasi* by sutures. The space between the newly adjusted half of the mouth and the neighboring cheek was closed by approximating the opposite parts and securing them to each other by sutures after their edges had been carefully matched. (Fig. 118 shows the result of this operation.)

HARELIP.

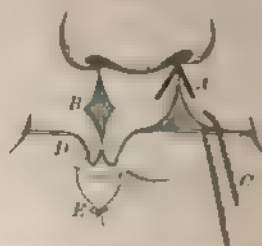
If the patient is a young child its arms should be securely bound to its sides with a towel, and its head firmly held by an assistant. After anesthesia has been obtained it can be easily kept up by applying to the nostrils from time to time sponges saturated with ether.

Single Harelip, Simple. The simplest method of operating is to pare the sides of the cleft and bring the raw surfaces together by a few sutures. The objection to the method is that the retraction of the scar produces a more or less considerable depression in the free border of the lip. It has therefore been generally abandoned for one of the following:

1. *Double Flaps* (Fig. 122). In order to hold the parts

upon the stretch and insure precision in making the cuts, a stout ligature should be passed through the lip at each angle of the cleft, or each angle should be seized with artery forceps. The lip being drawn forward and downward by means of the ligature or forceps, the mucous membrane is divided close to the gum and the dissection carried upward and backward as far as may be necessary to allow the sides of the cleft to be brought together without tension.

FIG. 122



Simple single harelip double flaps. *A* Incision. *B* Flaps turned down. Ligature for holding lip tense. *D* Incisions to shorten and adjust flaps. *E* Thread passed through the ends of the flaps.

Then making one side of the cleft tense, by drawing upon its ligature, the lip is transfixed near the angle and the incision carried upward along the border of the cleft to the top, or, if necessary, into the nostril, thus cutting out a narrow flap which remains attached at its lower extremity to the lip (Fig. 122, *A*). A similar flap is then made upon the other side, the two are turned down, so that their raw surfaces face other, and a thread passed through their ends (Fig. 122, *E*).

The freshened edges of the cleft are then confronted, a harelip pin placed near the vermilion border and another near the nostril, and two or three fine silk or silver sutures inserted between them. The ends of the dependent flaps are then cut off obliquely, enough being left to form a distinct projection on the lip after they have been united with fine sutures. By this means the formation of a notch in the retraction of the cicatrix is avoided.

2. When the cleft was shallow, Nélaton left the flaps attached to each other at the apex, turned them down, and

brought the raw surfaces together as above described (Fig. 123.)

3. *Single Flap* (Fig. 124.) A flap is made upon one side only, usually the shorter portion of the lip. The oppo-

FIG. 123



Harelip. Nislaton's method. A. Incision. B. Flap turned down.

site side of the cleft, and a portion of the free border of the lip adjoining it are freshened by the removal of a strip of skin and mucous membrane. The sides of the cleft are

FIG. 124



Harelip. Single flap.

approximated, and the flap applied to the free border of the lip.

FIG. 125



Harelip. Giraldez's method.

4. *Giraldez's Method* (Fig. 125). This is applicable only when the cleft extends into the nostril. The flap on

the short side is made, as before described, with its base below; that on the long side is reversed, being left attached at its upper end. A third, horizontal incision is carried outward from the edge of the nostril, at the point of the first flap, to make that portion of the lip more movable. The second flap is then turned upward across the nostril, the first brought down to take its place, and the two raw surfaces thus brought into contact united by sutures. The long side of the lip may also be mobilized, if desirable, by a horizontal incision running from the gap close below the columna and the corresponding nostril.

Double Harelip, Simple (Fig. 126). Flaps are made upon the lateral portions, *A* and *B*, as before described (p. 273, I), and the sides of the central portion, *C*, are pinned. The flaps are then brought together, as shown in the figure after mobilizing the lip by free division of the gingivo-labial fold and carrying the dissection well upward and outward. Pins passed to include the sides and the central portion at the base and apex of the latter, the flaps trimmed and united with fine sutures.

FIG. 126.



Double harelip.

If the parts are too scanty to permit the use of the method, liberating incisions must be made around the nostrils, or flaps obtained from the cheek. (See *Upper Lip*, p. 272 *et seq.*)

Complicated Harelip. Harelip may be complicated by fissure of the palate and alveolar process. When the case is single the bone on the long side of the lip projects beyond

its proper line. In very young children, it may sometimes be forced back into place by making pressure upon it with the thumb, but it is easier to fracture it first with Butcher's pliers; the bent blade of this instrument being applied upon the anterior surface near the further nostril. The two portions of the alveolar arch soon unite after they have been brought into contact, especially if the opposing surfaces have been pared. Sutures are not needed.

When there is *double fissure*, the intermediate portion of bone containing the incisor teeth projects so far that it seems to be an appendage of the nose rather than of the mouth. In order to restore it to its place, it is necessary to divide the vomer with strong scissors, or, better, to cut a triangular piece out of the septum of the nose. It is not necessary to fasten the bones together with sutures. The portion of skin covering the projecting bone must be dissected off, and used to lengthen the columna nasi or fill out the lip.

In extreme cases it may be proper to cut away the projection entirely; but whenever it can be saved and brought

FIG. 127.



Cheek compression.

into line, it renders valuable service by giving the upper jaw its proper length, and furnishing a space into which artificial teeth can be fitted. The three or four teeth which are found in this piece are always so defective and irregularly placed that they have to be drawn.

It is sometimes desirable to take the strain off the sutures

by means of a cheek compressor, similar to that represented in Fig. 127.

For uranoplasty, etc., see Operations upon the Mouth.

RHINOPLASTY.

The different kinds of rhinoplastic operations may be classified according to the nature and extent of the loss which they are designed to repair: 1st. A superficial loss not involving the bones or septum. 2d. Loss of the septum and nasal bones, the skin remaining entire. 3d. Loss of more or less of the surface and septum.

As the loss of tissue is always the result of injury or disease, it presents so many variations in form and extent, that it is difficult in practice to determine the exact boundaries between the classes, and this classification is chosen for convenience of description, and not with the intention of limiting the choice of an operation in any given case to those described in the class to which the lesion might belong. For the same reason, a description of an operation as actually performed will sometimes be more serviceable than any general rules that might be laid down.

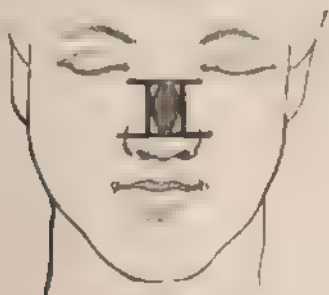
As may be readily understood, the existence or non-existence of the septum and nasal bones affects materially, not only the method of operating, but also the result. If unsupported centrally, the new member tends constantly to shrink and flatten, and the surgeon has the mortification of seeing that he has merely substituted one deformity for another. Ollier tried to meet this want by including the periosteum in the flap taken from the forehead by the Indian method. There was, however, no new formation of bone, and the operation in that respect was a failure. On another occasion he took a strip of healthy periosteum from one of the limbs, and tried to graft it under the skin of the forehead, hoping thereby to procure a lamella of bone, which could be used to give solidity to the new nose. Thinking the graft had failed, he withdrew the strip of periosteum after a few days, and then discovered that it had united merely at one point. There is reason, therefore, to think that a more patient repetition of the experiment might be

successful. On a third occasion, he included the periosteum of the forehead in a flap transferred by a modification of the French method, and by folding it together longitudinally along the centre he got reproduction of bone where the two layers faced each other.

1. *Superficial Defect not Involving the Bones or Septum.* If the loss of tissue is confined to the integument, that is, if the cartilage is spared, as it usually is in cases of epithelioma, no plastic operation should be undertaken. The tumor must be carefully dissected off, and the wound grafted or left to granulate. The slight mobility of the integument of the region prevents deformity by centric retraction, and the wound heals over, leaving a scar which does not contrast offensively with the neighboring skin.

If, on the other hand, there is a gap to be filled, one that is small and does not involve the free border of the ala, square lateral flaps may be made by horizontal incisions (Fig. 128), and drawn together after they have been rendered freely movable by dissection from the underlying parts.

FIG. 128.



Rhinoplasty. Lateral flaps.

If the gap is larger, or if one of the alae is lost, suitable oblique or vertical flaps may be taken from the nose or cheek and transferred by rotation. Three of the many variations of this method are shown in Figs. 129 and 130. Fig. 129, A, represents a vertical flap taken from the cheek beside and below the nose, and left adherent at its

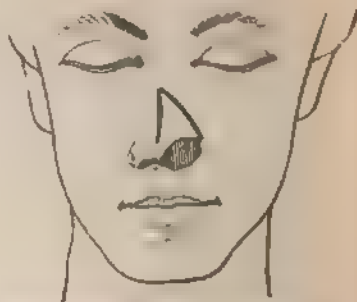
upper end. The flap should be cut long enough to allow a natural appearance to be given to the free border of the ala by turning it in upon itself. This device will also prevent excessive cicatricial contraction of the border and consequent narrowing of the nostril.

FIG. 129



Rhinoplasty. A. Single lateral flap.
B. Langenbeck's method

FIG. 130



Rhinoplasty. Denonvillier's method.

Denonvillier's Method (Fig. 130) sometimes makes it possible to secure this object more certainly by supplying a border that is already cicatrized. Supposing the lower portion of an ala to be lost, a triangular flap, left adherent to the lobe of the nose, is marked out by an incision which, starting from a point near the lobe on the unaffected side of the median line, is carried directly upward nearly to the root of the nose, and thence obliquely downward to the upper outer corner of the affected ala. The flap is mobilized by careful dissection of the bone and cartilage, and transferred downward. The gap left by the transfer heals by granulation or can be closed by a Thiersch graft. For the sake of giving more stiffness to the border, Denonvillier sometimes included a strip of cartilage in it.

*Von Langenbeck*¹ restored an ala by taking a triangular flap from the opposite side of the nose (Fig. 129, B). The flap was left adherent at the apex of the triangle, which lay near the inner angle of the eye of the affected side,

¹ *Manuel de Chirurgie Plastique d'après les Préceptes du Prof. B. von Langenbeck*, Bruxelles, 1883, quoted by Verneuil.

while its base occupied the opposite ala. It was dissected up carefully so as not to include the cartilage, transferred to the other side, and fastened to the freshened edges of the gap. The wound left by the removal of the flap healed by granulation, and so perfectly that it was difficult to recognize there had been any loss of tissue at that point.

Michon restored the ala by taking a triangular flap from the septum. The base of the flap was placed anteriorly, parallel to the ridge of the nose, and the apex lay near the junction of the septum with the floor of the nasal fossa. The flap was dissected up and attached to the margin of the loss of substance, its mucous surface directed outward, its apex made fast to the cheek.

The columna, with or without the tip of the nose, can be restored from the upper lip. *Dupuytren* and *Dieffenbach* cut a vertical cutaneous flap, adherent at its upper end, immediately below the columna, turned it upward, twisting it upon its pedicle so that its cutaneous surface remained external, and secured it in place. As the twisting of the pedicle created considerable deformity, *Sédillot* and *Blandin* made the flap of the entire thickness and length of the lip, pared off its cutaneous surface, and turned it directly upward without twisting the pedicle, the mucous membrane thus forming the outer surface. The gap left in the lip was then closed with sutures. In *Blandin's* case the result was excellent, and the mucous membrane gradually assumed the characteristics of ordinary skin; but in *Sédillot's* case, in which the tip of the nose had also to be restored, the membrane remained red and covered with thick epidermic scales, and the end of the nose looked much like a cherry.¹ In all his rhinoplastic operations *Liston* made the columna separately by this method, and found that the mucous membrane soon took on the appearance of ordinary integument.

2. *Loss of the Septum and Nasal Bones, the Skin remaining entire.* Baron *Larrey*, about 1820, operated upon a soldier the bridge of whose nose had been shattered and depressed by the explosion of a gun. He removed the deformity by dissecting up the adherent portions of skin and

¹ *Sédillot Médecine Opératoire*, 2d ed., vol. II. p. 233.

replacing them in their original position. The details of the operation are lacking.

Dieffenbach published in 1829 the description of an operation by which he overcame the great deformity resulting from the loss of the septum and bones of the nose by scrofulous disease. As the case is a classical one, quoted, and often very incorrectly,¹ in the text-books, and is an indica-

FIG. 131.



Dieffenbach's operation. B The result. C. The flaps.

tion of what may sometimes be accomplished in extreme cases, the following description of it is given:²

The patient was a girl twelve years of age. She had lost the ossa nasi, nasal process of the ethmoid, vomer, and cartilages, and instead of a prominent nose there was a deep pit with a ridge at the bottom. The plan of operation was to divide the remains of the old sunken member into portions, raise them up, and secure them in the proper position. Dieffenbach passed a narrow-bladed knife first

¹ The description in *Hearnes's System of Surgery*, vol. v, p. 570, is almost unrecognizable. It is taken from Malpighi's incorrect account, and also contains at least one gross error in translation.

² As the original work could not be obtained, this description is made up from an English translation of the book published in 1828, a French translation of the same in the *Année Médicale* for 1828, 1829, and a third (see, p. 11) with notes, in a collection of Dieffenbach's Plastic Operations published by two of his pupils in 1840.

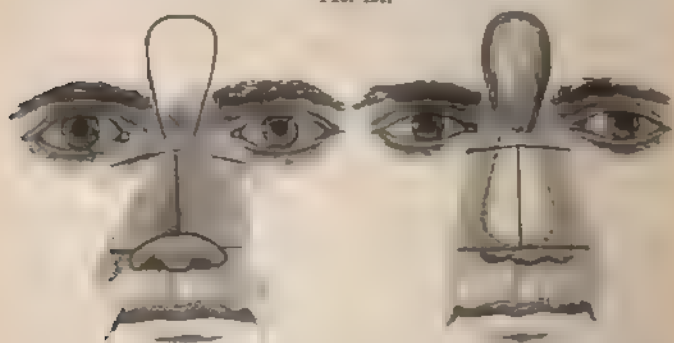
into one nostril and then into the other, and cut out, making two incisions, one on each side of the sunken ridge (Fig. 131, C). The strip of skin between these incisions was three times as broad at its lower end, where it was connected with the upper lip by the shortened columna, as at its upper part where it joined the forehead. The cheeks were next cut through down to the bones on each side by inserting the knife a few lines below the upper end of the first incision and carrying it obliquely downward, parallel and a little external to the side of the nose, and then around into the nostril, thus separating the lateral attachments of the *ala nasi*. The columna, being too short, was then elongated by two slight incisions in the upper lip, and the cheeks rendered more movable by dividing their attachments to the bone through the lateral incisions. The flaps were then raised, the sides of the incisions pared obliquely in a manner to which Dieffenbach attaches an importance that seems undeserved, reunited, and fixed with barrel pins and sutures, and the whole retained in place by drawing the cheeks toward the median line and fastening them there with two long pins passed under the nose and through the detached edges of the cheeks. This compression was aided by two splints of leather through which the pins passed. A quill covered with oiled lint was introduced into each nostril.

Osteoplastic Method—Ollier treated successfully a somewhat similar case by making a triangular flap, its base constituted by the lower portion of the nose and the adjoining cheeks, its apex situated one and a half inches above the eyebrows. The frontal portion of the flap included the underlying periosteum. The left nasal bone and vomer having been destroyed by the disease, central support could be obtained for the new nose only by aid of the right nasal bone, which was accordingly loosened with a chisel and forced downward. The flap was then transferred downward, pinched in laterally to increase its height at the bridge, and supported there by drawing the cheeks, previously loosened from their underlying attachments, toward the nose and fastening them there with long pins.¹

¹ For further details of this operation the reader is referred to the original account in the *Bulletin de la Société de Chirurgie*, 1862, p. 62, and to its reproduction.

Double Layer, or Superficial Flaps (Fig. 132). Verneuil¹ employed successfully a method suggested to him by Ollier, in which permanent elevation of the bridge of the nose was secured by superposing two flaps and thereby doubling the thickness. The patient had discharged a pistol into his mouth, causing the destruction of a portion of the hard palate and septum, the nasal bones, part of the nasal processes of the superior maxillary, the spine of the frontal, and the anterior wall of the frontal sinuses. The alae and lobe were uninjured but much flattened; above them was a broad deep groove extending to the middle third of the forehead. The two principal indications were to bring the lateral portions nearer the median line and to reconstitute the bridge of the nose. The latter could be permanently accomplished only by filling in the great cavity which would be left by raising the sunken parts.

FIG. 132.



Rhinoplasty, sunken nose. Double layer, or superposed flaps. Verneuil

Verneuil made an incision along the median line of the depression and a transverse one at each end of the first, and dissected up the two lateral flaps thus marked out. He then raised an oblong flap from the middle of the forehead, its base remaining adherent between the eyebrows,

¹ In *Verneuil's Chirurgie Reparatrice*, p. 428, and in the *Gazette Hebdomadaire*, 1881, p. 98, and also to a rhinoplasty operation described more fully on pp. 288-290 of this manual.

² *Chirurgie Reparatrice*, p. 428, and *Bull. de la Soc. de Chirurgie*, 1882, p. 70.

and turned it directly downward so that its raw surface was directed outward, its tegumentary surface toward the nasal fosse. The two lateral flaps were then placed upon it and united in the median line. The raw surfaces united with each other, and the result was a nose elevated one-third of an inch above the adjoining surface.

Subcutaneous Method. Prof. Pancoast¹ operated upon a similar case in the winter of 1842-43 by subcutaneous division of the adhesions. The ossa nasi and septum had been entirely destroyed by disease, and the nose was sunken far below the level of the face. "A narrow long-bladed tenotomy knife was introduced on either side by puncture through the skin over the edge of the nasal process of the upper maxillary bone. The knife was pushed up under the skin to the top of the nasal cavity, and then brought down, shaving the inside of the bony wall, so as to detach the adherent and inverted nose upon either side. The point of the nose could now be drawn out. . . . The nose still remained adherent to the top of the nasal chasm. The knife was a third time introduced under the skin in a direction corresponding nearly with the long diameter of the orbits of the eyes and the adhesions separated from the nasal spine and internal angular processes of the os frontis." The soft parts on the cheek were loosened by sweeping the knife outward along the surface of the bone so far as to divide the infra-orbital nerve and artery on each side, drawn toward the median line, and held together with quilled sutures passed through the cavity of the nose.

In two weeks the root of the new nose had sunk to the level of the face, but the patient was well satisfied, and refused any further operation, beyond the removal of an elliptical piece of skin to raise this portion again. The ultimate result is not known.

Dubruell² quotes a similar operation by Malgaigne, but without giving the date. As it is not mentioned in the latter's *Médecine Opératoire*, edition of 1837, it is probable that Prof. Pancoast's operation antedates it.

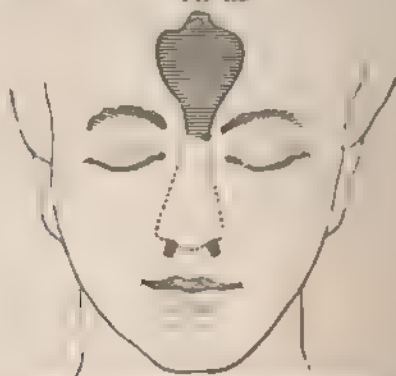
¹ *Operative Surgery*, Phila., 1852, p. 258.

² *Médecine Opératoire*, p. 451.

3. *Loss of more or less of the Surface and the Septum.*

A. *Indian Method.* This method was introduced into Europe in 1814, by Carpue, an English surgeon, and the stimulus given by it to this class of operations was so great during the succeeding twenty-five or thirty years that this period has been called that of the *renaissance* of rhinoplastic surgery. The ultimate results, however, were not very favorable, and the method has fallen into comparative neglect. It was found that the noses, although sufficiently full, or even *excessive* at the time of the operation, underwent gradual atrophy, and, when central support was lacking, sank to the level of the cheeks. The nostrils, too, closed sometimes to such an extent that they would hardly admit a probe; and, finally, the whole flap had a tendency to slide downward, and collect in a lump at the end of the nose after division or excision of the pedicle. The scar left upon the forehead was a serious disfigurement, and the attempt to diminish it by drawing the sides of the gap together gave rise to complications, which endangered the patient's life. The operation itself was not without danger. Dieffenbach lost two out of six patients upon whom he operated in Paris.

FIG. 133.



Rhinoplasty. Indian method unmodified

The operation was originally performed as follows (Fig. 133): A flap, the size and shape of which were determined by a pattern previously made of paper or card, was marked

out upon the forehead immediately above the nose. Care was taken to make it at least a quarter of an inch broader and half an inch longer than the space it was to fill. Its base was situated between the eyebrows, and was half an inch broad. At the upper end of the flap was a projecting tab intended to form the columna. The flap, including all the tissues down to, but not through, the periosteum, was then dissected up, brought down by twisting the pedicle, placed in its new position with its raw surface inward, and attached by sutures to the freshened edges of the gap it was to fill. Prominence was given to the ridge by stuffing the nostrils with plugs of oiled lint, or drawing the cheeks toward the median line by means of long pins passed transversely through the edges and under the nose. The gap in the forehead was left to heal by granulation. After the flap had united, the pedicle was divided, and returned to its original position.

*Modifications.*¹ Larrey (1820) pointed out the desirability of saving even the smallest fragments of the original nose, especially if they belonged to the free border of the ala. Prof. Bouisson² formulated this principle, and extended it to the other methods, as follows: 1st. Save as much as possible of the septum. 2d. Give lateral support to the flaps by means of the healthy portion of the cartilage of the alæ. 3d. Insure the regularity of the outline of the nostril by giving the lower border of the flap cartilaginous support. Dupuytren and Dieffenbach opposed the retraction and closure of the nostrils by folding back upon itself that portion of the edge of the flap which was to form the free border.

The torsion of the pedicle involves more or less danger of gangrene by obstructing the return of the venous blood. Lisfranc (1826) was the first to attempt to diminish this defect. By lengthening the incision on one side, the base or attachment of the pedicle was made oblique instead of transverse, and the torsion correspondingly diminished at

¹ The dates of these modifications and the names of credit for their suggestion are mainly taken from Vol. I., *Chirurgie Expérimentale*, to which the reader is referred for further details and documentary proof.

² *Rhinoplastie latérale*.

that point. Of course, the total amount of torsion remained the same, but, by being spread along the pedicle, it was made more spiral and less abrupt. Von Laugenbeck (before 1856) went a step further, and put the base upon the side of the nose close to the eye, the upper incision ending at the eyebrow, the lower just below the tendo oculi. Labbat did about the same thing in 1827.

Auvert, a Russian surgeon (date unknown, but long before 1850), made the flap oblique instead of vertical, still keeping the base between the eyebrows. Alquié, of Montpellier (1850), proposed to make the flap horizontal, the lower incision being hidden by the eyebrow; and Landreau even curved it somewhat upward at the end, so that the base of the pedicle was hardly twisted at all in bringing down the flap. Ward (1854) made a flap which was directed obliquely upward, and Follin (1856) made a transverse one; in each case the base of the pedicle was upon or near the median line of the forehead, a little above the eyebrows. Both cases did well. The objection to a transverse flap is that the retraction of the cicatrix upon the forehead draws the corresponding eyebrow upward. The advantages are that the torsion is less, and the scar somewhat disguised by the natural lines.

Various means have been employed to prevent the descent of the flap. Dieffenbach made a longitudinal incision on the side of the nose, and engaged the pedicle in it, paring off its prominences afterward. Blandin excised the portion of skin intermediate between the base of the pedicle and the loss of substance, and thus obtained a raw surface to which the whole length of the pedicle was then united. Instead of excising this intermediate piece of skin, Buck left it attached by its upper end, and used it to cover part of the gap left upon the forehead. Velpeau divided the pedicle close to its base, trimmed it to a point, and engaged it in a vertical incision made in the underlying skin.

B. *Ollier's Osteoplastic Method* (Fig. 134). A lupus had destroyed the alæ, columna, lobe, cartilages, and part of the septum. The nasal bones were uninjured, but had suffered an arrest of development, and were bounded in-

feriorly by a strip of cartilage. The nose was not more than an inch long. The skin of the cheeks and lips had also been involved by the lupus, and, therefore, could not be used for the restoration.

Starting from a point in the median line of the forehead two inches above the eyebrows, Ollier made two incisions diverging downward, each of which ended a quarter of an inch to the outer side of the lower border of the nasal orifice.

In dissecting up the long triangular flap thus marked out, he included the periosteum from above downward as far as to the upper end of the nasal bones; he then continued the dissection along the right nasal bone, leaving the periosteum adherent to it, and on reaching the lower end of the bone he separated from it the cartilaginous strip above mentioned, leaving it adherent to the flap.

On the left side he divided, with a chisel, the bony connections of the left nasal bone, leaving the bone attached to the flap by its anterior surface; this was accomplished by introducing the chisel, first between the two nasal bones,

FIG. 124.



Rhinoplasty. Ollier's osteoplastic method.

then between the left nasal bone and the frontal, and finally between the left nasal bone and the nasal process of the superior maxillary. Drawing the flap downward, he then divided the cartilaginous septum from before backward and

downward with scissors, so as to have an antero-posterior flap of cartilage attached by its base to the cutaneous one, and able to furnish central support for the new nose by resting its free border upon the floor of the nasal fossa, or rather upon the remains of the lower portion of the original septum.

He next drew the whole flap downward until the upper border of the left nasal bone came into line with the lower border of the right nasal bone, and then fastened the two bones together with a metallic suture. The sides of the flap were then united to the cheeks, and those of the frontal incisions drawn together above the apex of the flap.

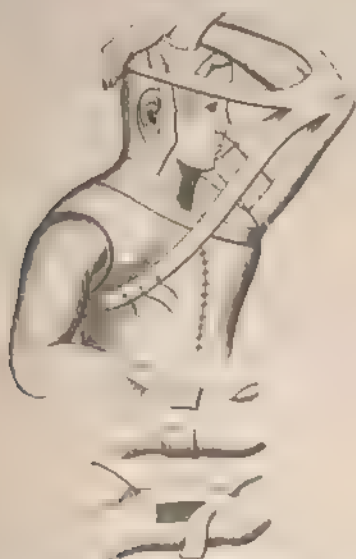
The parts united, the space left by the removal of the left nasal bone was filled with bone produced by the periosteum brought down from the forehead, and the result was satisfactory.

C. Alquié used a flap of similar shape in a case in which the alæ and septum were lost, but the columna remained. The apex of the triangle was placed in the space between the eyebrows, and the incisions diverged downward and outward. With a narrow tenotome passed along the incisions he separated the skin entirely from the nasal bones and was then able to depress it far enough to attach it to the freshened end of the columna.

D. *Italian Method* (Fig. 135). Tagliacozzi made two nearly parallel incisions along the anterior surface of the arm, their length and the distance between them varying according to the size of the gap the flap was to fill. The apex of the flap was directed toward the shoulder. The intermediate strip of skin was dissected up, but left adherent at both ends, and a piece of oiled lint passed under it and kept there until suppuration was established. The strip was then cut free at its upper end, and dressed carefully for about a fortnight, or until its under surface was nearly cicatrized. It was then considered fit to be applied, having undergone the necessary shrinking and thickening. Its edges and those of the nasal aperture were pared and fastened together with sutures, and the arm bound fast to the head. When union had taken place between the two, the lower end of the flap was cut loose from the arm and its edges trimmed to the proper shape.

Graefe did not let the flap suppurate, but tried to get primary union.

FIG. 135.



Rhinoplasty Italian method.

Dr. Thomas T. Sabine successfully filled by the implantation of a finger the gap left by the destruction of the nose.

PLASTIC OPERATIONS UPON THE EYELIDS.

In these operations it is important to save as much as possible of the original tissues, especially the free border of the lid, the conjunctiva, and the orbicular muscle. As the skin is thin and delicate, the flaps must have broad bases to insure their vitality; they must also be so placed that their natural retraction will not tend to re-establish the previous defect.

Blepharorrhaphy. Suture of the eyelids has proved a very valuable adjunct of many of the plastic operations upon

the eyelids, and has even taken the place of some of them, for experience has shown that a loss of substance in either eyelid may be safely allowed to fill and heal by granulation if the borders of the lids are kept fastened together. The eye must be kept closed in this way for six months or a year, after which time the scar, in most cases, shows no tendency to retract. When the time comes to separate the lids, this should, at first, be done for only half an inch in the centre, and the opening subsequently enlarged at long intervals of time, any indication of cicatricial retraction being meanwhile watched for.

The prolonged occlusion does no harm to the eye; on the contrary, it may be sufficient in itself to cure a commencing keratitis occasioned by ectropion.

Operation A narrow strip of conjunctiva is excised from the border of each lid on the conjunctival side of the lashes, beginning and ending a short distance from the com-

FIG. 135.



Canthoplasty. A. Straight incision. B. Richet's modification

missures, so as to leave a space for the flow of the tears. The two raw surfaces are then brought together accurately with silver sutures.

To separate the lids afterward a director should be entered at the opening left at one of the angles, its point pressed against the centre of the line of union, and cut down upon the two rows of lashes.

Canthoplasty. Enlargement of the palpebral opening (Fig. 136). The external angle of the eye is divided horizontally with scissors, and the skin and conjunctiva united

along the sides of the incision by three points of sutures, one of them being placed at the angle.

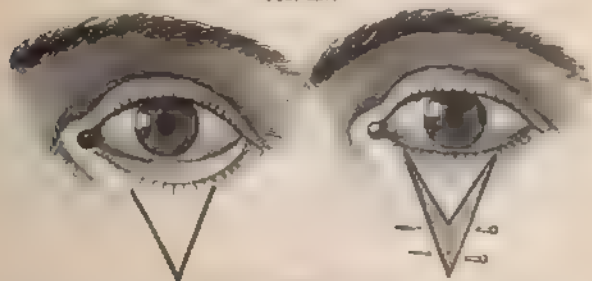
Richet's modification¹ (Fig. 136, B). Richet marks out a small flap by two incisions through the skin, beginning at opposite points on the upper and lower lids near the outer angle and meeting at a point external to that angle. The flap, including everything except the conjunctiva, is then excised, the conjunctiva split horizontally, and its two portions trimmed and fastened to the edge of the cutaneous incisions.

Blepharoplasty, to prevent or remedy—

1. *Ectropion*. The descriptions will be given for the lower lid only, that being the more frequent seat of the deformity. Blepharoraphy (*q. v.*) is often sufficient in itself to prevent ectropion, and is always a useful adjunct of a plastic operation. The lids should be kept united during the process of cicatrization of the wound left by the loss of substance, and for several months thereafter.

Wharton Jones (Fig. 137). Wharton Jones included the contracted cicatrix in a triangular flap one inch high, its base occupying nearly the whole length of the lid border.

FIG. 137.



Ectropion. Wharton Jones

By dividing the bands of cellular tissue, but without dissecting up the flap, he restored the lid to its normal position, and held it there by uniting the edges of the incision below, thus giving it the form of a Y.

¹ *Anatomie Médico-Chirurgicale*, 4th edition, p. 55.

*Alphonse Guérin*¹ (Fig. 138) makes two incisions forming an inverted V, the point of which lies just below the centre of the free border of the lid. From the lower extremities of these incisions he makes a third and fourth parallel to the border of the lid. The two triangular flaps bounded by the 1st and 3d, and the 2d and 4th incisions

FIG. 138.



Ectropion Alphonse Guérin

are then dissected up, the lid raised to its normal position, and held there by uniting the adjoining sides of these two flaps in such a manner that their apices and that of the inverted V meet at a common point. The gaps left by the removal of the two flaps are allowed to granulate, or covered with Thiersch grafts. For greater security Guérin also unites the borders of the lids (blepharoraphy).

FIG. 139.



Ectropion A Von Graefe's method B Knapp's method.

Von Graefe (Fig. 139, A). Make an incision along the border of the lid just outside of the lashes from the lachrymal point to the external commissure. From each extremity of this make a vertical incision downward from one-

¹ *Chirurgie Opératoire*, 4th edition p. 313.

half to three-quarters of an inch in length. These incisions should involve only the skin. Cut off the upper inner corner of this flap, not by a straight incision, but by one forming an angle, as shown in the figure, and fasten this angle by a suture to that formed by the border of the lid and the inner vertical incision. Reunite the edges of the transverse incision, cutting the ends of the sutures long enough to reach to the forehead, and then fastening them there with adhesive plaster. The excision of the inner angle of the flap raises the eyelids by shortening its border.

Dieffenbach, *Adams*, and *Ammon* have proposed other methods of shortening the lid. They are indicated in Fig. 140, where the shaded spaces represent the portions of skin to be removed, and the threads the manner in which the edges are afterward brought together. *Adams's* excision included the whole thickness of the lid.

Richet (Fig. 141). *Richet* makes an incision parallel to the border of the lid, half an inch below it, and extending nearly from one angle of the eye to the other. The lid, having been freed by this incision, is then united to the other (blepharoraphy).

FIG. 140



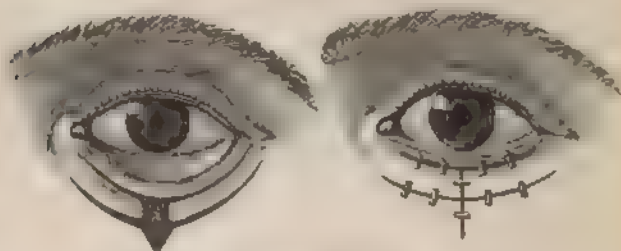
Exotropion A *Dieffenbach* B *Adams* C *Ammon*. The shaded spaces indicate the portions of skin removed the threads show how their edges are brought together

He next makes a second incision parallel to the first and one-third of an inch below it, divides the intermediate strip of skin vertically in the middle and dissects up its two halves. Immediately below the lower end of this vertical incision he removes from the lower border of the second incision a V-shaped flap of skin, its point directed downward. He then raises the two halves of the middle flap, brings them again into contact with the border of the lid,

excises their superfluous length, and unites them. The sides of the V are then brought together and the edges of the incisions reunited.

Knapp (Fig. 139, B). *Knapp* employed the following method to remove an epithelioma occupying the inner por-

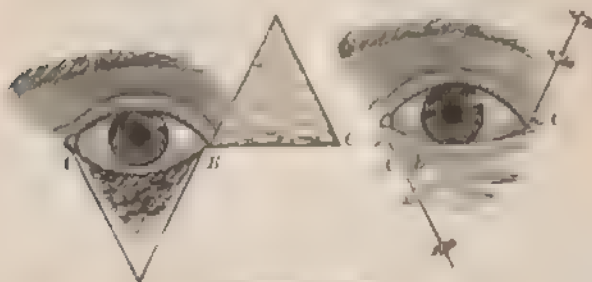
FIG. 141.



Ectropion. Richet.

tion of the lower eyelid, the free border of which was involved. He circumscribed the tumor by two vertical and two horizontal excisions and excised it. The horizontal incisions were then prolonged on both sides, the lower external one being inclined downward so as to make the base of the flap broader, the two flaps dissected up, drawn together and united by their vertical edges.

FIG. 142.



Ectropion. Burrow

Burrow (Fig. 142). The loss of substance is made triangular in shape, the apex directed downward; the base

is then prolonged horizontally outward, and an equal and similar triangle marked out upon the upper side of the prolongation. The skin contained within the second triangle is then excised, and the irregular flap bounded by the outer sides of the two triangles and the prolongation of the horizontal incision dissected outward and downward, and then moved toward the median line until it covers both the open spaces.

It is not necessary that the two triangular spaces should touch at one corner; they may be an inch, or even more, apart; but they must of course be connected by the horizontal incision.

Dieffenbach (Fig. 143). When the cicatrix or tumor was large *Dieffenbach* gave the loss of substance a triangular shape, the apex directed downward. He prolonged outward the horizontal incision forming the base of the triangle, and carried another incision downward and inward from its outer extremity. The quadrilateral flap thus marked out was dissected up and carried inward to cover

FIG. 143.



Ectropion Dieffenbach

the loss of substance. The gap left by its removal was then drawn partly together with sutures, and the remainder left to granulate.

Indian Method *Sédillot* refers the first blepharoplasty by the Indian method to *Von Graefe* in 1809. As this was previous to the introduction of rhinoplasty by the same method, the idea was probably entirely original with *Von Graefe*. The case is mentioned in his *Rhinoplastik*, 1818, but without details. The flap can be taken from the fore-

head or cheek; it should be very large and should include the subcutaneous cellular tissue. Fricke, of Hamburg, took a vertical flap from the temporal region to restore the upper eyelid.

One of the modifications of this method, intended to obviate the necessity of dividing the pedicle, is shown in Fig. 144, *A*.

Richet (Fig. 144, *B*). The lids are freed by two incisions inclosing all the cicatricial tissue, and then united

FIG. 144.

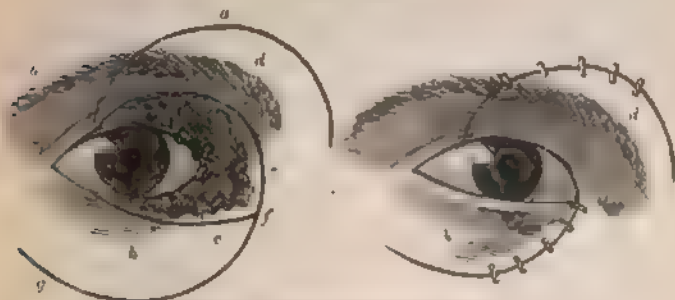
Ectropion. *A* Modified Indian method. *B* Richet.

(blepharoraphy), the sutures being cut long and their ends fastened upon the forehead. Two flaps are then marked out as shown in the figure, the external one, *C*, raised and used to cover the original loss of substance, and the inner one, *D*, used to fill the gap occasioned by the removal of *C*.

Hasner d'Artha (Fig. 145) employed the following method in a case where a tumor occupied the commissure and inner portion of each eyelid. He made a curved incision, *a*, beginning at the border of the upper eyelid beyond the limit of the tumor, crossing the eyebrow to the forehead, and then crossing downward to terminate near the root of the nose. A second curved incision, *c*, began at the same point as the first and was carried along the upper and inner edge of the tumor to the point marked *f*. A third curved incision, *e*, began on the border of the lower lid beyond the limit of the tumor and was carried along the lower margin of the latter to the point *f*. A fourth curved incision, *g*, parallel to the border of the lower lid, was carried from the point outward to the cheek.

The tumor and the portion of the lids circumscribed by the incisions *c* and *e* were then removed, and each of the flaps *d* and *h* dissected up to its base. The former was lowered, the latter raised, and the excess of each cut off. The upper border of the flap *h* formed the free border of

FIG. 145.



Ectropion Hasner d'Artha's method

the lower lid, and the lower border of the flap *d* formed the free border of the upper lid and the commissure corresponded to the apex of the flap *h*. The skin of the forehead and cheeks was mobilized and reunited to the flaps (Dubrueil).

FIG. 146.



Ectropion Denonvilliers's method "by exchange"

Denonvilliers's method "by exchange" (Fig. 146). In a case of ectropion of the lower lid, with deviation of the outer angle of the eye downward, Denonvilliers used the

following method : By making three incisions to meet in the form of **Z**, he marked out two adjoining triangular flaps ; one of them included the outer angle of the eye, the apex of the other was situated upon the forehead just above the eyebrow. He then dissected up the flaps, restored the angle of the eye to its proper position, brought the upper flap down into the gap made by the lower incision, and the lower flap up into that made by the upper incision.

Ectropion due to excess of the conjunctiva may be treated by cauterization of the conjunctiva, or by excision of a portion. The latter operation is simple ; a fold is pinched up with forceps and excised with knife or scissors. The edges of the gap may then be brought together by sutures or left to granulate.

2. *Entropion.* *Canthoplasty* (q. v.) may be employed to remedy moderate entropion, especially if it be due to spasm of the orbicularis.

Ligature (Fig. 147), proposed by Gaillard to remedy trichiasis, is equally applicable to the cure of entropion.

FIG. 147.



Entropion : Ligature.

A transverse fold is pinched up, and a needle carrying a stout ligature passed through its base, shaving the anterior surface of the cartilage. The ligature is tied and allowed to cut through the skin. The resulting linear cicatrix maintains the lid in the position given it by the ligature.

Rau has modified this by placing several ligatures instead of only one.

Excision or cauterization of a fold of the skin is applicable to cases of entropion due to laxity of the skin of the

eyelid. A transverse or a vertical fold is pinched up quite near to the margin of the lid and excised; the borders of the wound are united by sutures. Instead of excision, cauterization of the strip, preferably with sulphuric acid, is sometimes used.

Von Graefe (Fig. 148) treated a case of spasmodic entropion by removal of a triangular piece of skin. He made a cutaneous incision parallel to the free border of the lid, and about a line from it, and excised a triangular cutaneous flap, the base of which occupied the median portion of the first incision. The sides of the wound left by the excision of the triangular piece were then drawn together with sutures.

For spasmodic entropion of the upper lid, with retraction of the tarsal cartilage, Von Graefe modified the operation

FIG. 148



Entropion—lower lid Von Graefe

FIG. 149



Entropion—upper lid Von Graefe

as follows (Fig. 149): After excision of the triangular cutaneous flap, he drew the sides of the wound apart, divided the orbicular muscle horizontally near the edge of the lid, and drew it upward, exposing the cartilage. He then excised a triangular piece of the cartilage, the apex being at its lower border, taking care not to include the conjunctiva in the dissection. The sides of the cutaneous wound were then drawn together with three sutures, the middle one of which included also the sides of the gap left in the cartilage.

Excision of a Portion of the Orbicularis. Key cured a case of spasmodic entropion by excising a few fibres of the orbicular muscle. He made an incision through the skin

parallel to and near the free border of the lid, exposed the muscle, and removed a bundle of fibres from its central margin. It is well to combine this with removal of a horizontal strip of skin.

Division or Resection of the Tarsal Cartilage. When the entropion is caused or maintained by shortening or incurvation of the tarsal cartilage, the operation must be directed to the removal of this cause.

Vertical division at one or two points of the entire thickness of the lid has been employed. After having been divided, the border of the lid is held in its proper position by ligatures passed through it and fastened to the forehead (upper lid) or cheek (lower lid), while the wound fills and heals by granulation.

A horizontal incision through the conjunctiva from one vertical incision to the other makes it easier to turn the lid out and hold it in place.

Longitudinal Tarsotomy (Ammon). The eyelid having been turned out, a knife is passed through it from the con-

FIG. 150.



Knapp's modification of Desmarres's forceps.

junctival side, quarter of an inch from the border, and on a line with the lacrimal point, and an incision made parallel with the border nearly to the outer angle. A longitudinal strip of skin is then excised, and the edges of the gap left by the excision are drawn together. By this means the free border of the lid is drawn away from the surface of the eye, turning upon the longitudinal incision as upon a hinge.

Excision of part of the Cartilage (Streatfeild), (Fig. 151).

The eyelid is fixed with Desmarres's forceps (Fig. 150), the flat blade against the conjunctiva, and an incision made parallel to the border of the lid at the distance of one line from it, and carried to a depth sufficient to expose the bulbs of the eyelashes. The surgeon, raising the edge of the skin, passes around the bulbs to the tarsal cartilage, and then makes a second incision at a greater distance from the border of the lid than the first one was, meeting the first at its two extremities and inclosing with it an oval strip of skin. These two incisions are carried into the cartilage, circumscribing a longitudinal wedge-shaped strip, the apex of which reaches nearly to the conjunctival side of the cartilage. The wound is left to heal by granulation, with the expectation that the contraction of the cicatrix will overcome the entropion.

FIG. 151

Entropion
Stretefield's
method.

3. *Symblepharon.* When the adhesion between the two layers of the conjunctiva is incomplete, that is, when it does not extend to the bottom of the sulcus between the lid and eyeball, it is sufficient to throw a ligature around it. After the ligature has cut through, the tabs are successively excised, and the borders of each wound drawn together or left to heal by granulation. To avoid reunion of the surfaces, the second tab should not be removed until after the wound left by the removal of the first has healed.

When the adhesion is complete, but not broad, a thread or silver wire may be passed through its base and tied loosely around it. After the hole made by the wire has cicatrized the adhesion is divided. The narrow line of cicatrix left at the bottom of the fold by the wire favors the separate healing of the two sides of the incision.

Art's Method. A thread is passed through the fold close to the cornea, and the symblepharon dissected away from the eyeball. Each end of the thread is then attached to a needle and passed through the lid from within outward at the bottom of the wound. By drawing upon the thread and tying it outside the lid the symblepharon is folded upon itself and its point fixed at the bottom of the sulcus. The edges of the wound on the eyeball are then drawn

together with sutures, the conjunctiva being loosened by dissection, if necessary.

Teale's Method (Figs. 152, 153, 154). This symblepharon is separated from the ball of the eye by an incision along the line of its union with the cornea, and dissected down to the bottom of the fold as in Arlt's operation, its

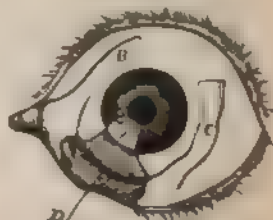
FIG. 152



A

Symblepharon

FIG. 153



B, C. The flaps.

apex, however, being left upon the cornea. Two long, narrow conjunctival flaps, *B* and *C*, are then dissected up on opposite sides of the eyeball, their bases directed toward the symblepharon, their borders parallel to that of the cornea. These flaps should not include the subconjunctival tissue. The inner flap *B* is brought down and fast-

FIG. 154



Flaps in place

ened to the denuded surface of the eyelid, the outer flap *C* covers that of the eyeball. They are fastened in place by means of fine sutures, and the edges of the gaps left by their removal brought together in the same manner.

Ledentu's Operation. Where one lid was adherent throughout its entire length, Ledentu divided the adhesion

to a depth equal to that of the normal fold, dissected a long conjunctival flap from the other half of the eye, leaving it adherent at both ends, brought it down across the cornea, and applied it to the raw surface left on the eyeball by the division of the adhesion. This flap should be at least one-third of an inch broad.

4. *Pterygion. Excision.* The pterygion is pinched up with forceps, a knife passed flatwise under it close to the cornea, and the portion of the growth which corresponds to the latter shaved off. The edges of the conjunctival wound are then drawn together with sutures.

Scissors may be used instead of the knife; in that case the incision must begin at the point of the growth.

Ligature, Szokalski (Fig. 155). A thread is passed under the pterygion by means of two small curved needles,

FIG. 155.



Pterygion ligature.

as shown in Fig. 155. The thread is cut close to the needles, and thus made to furnish three ligatures, one at each end, encircling the growth at right-angles to its long axis, and one in the middle, encircling its implantation upon

the sclerotic. The ligatures are tied tightly, and the inclosed portion falls in a few days.

5. *Trichiasis*. Temporary removal of the deviated lashes is seldom effectual. Permanent removal by destruction of their bulbs, or excision of the border of the lid, is now considered unjustifiable. The direction of the lashes may be changed by operation upon the lid. The retraction following excision of an oval strip of skin, or the use of ligatures as in entropion, is sometimes sufficient, but it may be necessary to act more directly upon the lashes. Simple splitting of the external canthus may be sufficient.

Von Graefe's Method. An incision is made along the free border of the lid on the conjunctival side of the deviated lashes. From each end of this a vertical incision is next made through the free border and the skin. The flap thus circumscribed and containing the lashes is dissected up a short distance. It is then easy to fasten it with sutures in such a position that the lashes can no longer touch the eyeball.

Anagnostakis made a cutaneous incision parallel to the border of the upper lid and one-eighth of an inch from it, exposed the orbicular muscle by drawing the skin up, and excised that portion of it which corresponded to the upper part of the tarsal cartilage. The lower edge of the cutaneous incision was then drawn up and fixed to the fibro-cellular layer covering the cartilage by means of three or four sutures, which were then allowed to cut themselves out.

PART VII.

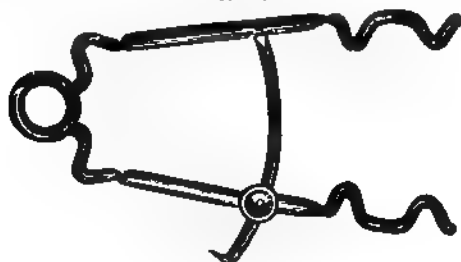
SPECIAL OPERATIONS.

CHAPTER I.

OPERATIONS UPON THE EYE AND ITS APPENDAGES.

IN most operations upon the eye the lids should be held open by an eye-speculum (Fig. 156), and the eyeball fixed

FIG. 156.



Eye-speculum.

by pinching up a fold of the conjunctiva with toothed forceps.

The instillation of a few drops of a 4 per cent. solution of the hydrochlorate of cocaine under the lids will make most operations painless, but the sensitiveness of the iris is not thereby abolished.

THE CORNEA.

Removal of a Foreign Body. When the foreign body has penetrated to only a slight depth, it may be easily removed

with the point of a knife or fine forceps; but, if it lies so near the posterior surface of the cornea that there is danger of forcing it through into the anterior chamber by the efforts made for its extraction, a lance-shaped knife must be entered very obliquely and passed behind it, between the layers of the cornea if there is sufficient space, otherwise within the anterior chamber.

If the foreign body falls into the anterior chamber, notwithstanding these efforts to prevent it, the surgeon must wait until the aqueous humor has reaccumulated, and then make an incision three or four millimetres in length at the lower portion of the periphery of the cornea, in the hope that the foreign body will be washed out during the flow of the liquid.

Puncture of the Cornea. This may be made with a broad needle or a well-worn Beer's knife. It is advisable to employ anaesthesia, and to steady the eyeball with fixation forceps. The surgeon stands behind the patient, raises the upper lid, and fixes it against the margin of the orbit with two fingers of his left hand, which also rest against the inner side of the eyeball and prevent it from rotating inward. The needle or knife is then entered a little in front of the edge of the cornea at the outer side. Its direction must be sufficiently oblique to avoid injury to the iris, and not so much so that the instrument will remain between the layers of the cornea and fail to penetrate to the anterior chamber. By partly withdrawing the instrument and twisting it slightly, the incision is made to gape and allow the escape of the liquid; or a fine blunt probe may be passed into the incision after entire withdrawal of the needle. Subsequent tapplings are effected by reopening the original wound with the probe. Figure 157 represents a combined needle and probe. The needle is provided with a shoulder to prevent its introduction to too great a depth.

Excision of the Globe for Staphyloma. The sclerotic is incised with a Beer's knife just in front of the insertion of the external rectus; into the opening is passed one blade of a pair of small blunt-pointed scissors, and the anterior portion of the globe is cut away, with the lens and all the

FIG. 167



Stop needle and probe for
puncturing the cornea.

FIG. 168



Bear's knife.

vitreous humor. The wound is then closed with catgut sutures passed through the conjunctiva alone.

THE IRIS.

Iridotomy. Incision of the iris may be performed for the purpose of establishing an artificial pupil. As its success depends upon the retraction of the divided fibres, it should be undertaken only when their contractility is not interfered with by too extensive adhesions, or has not been destroyed by disease. The more common lesions to which the operation is applicable are central opacity of the cornea, occlusion of the pupil, and excessive prolapse of the iris after removal of a cataract; but the danger of injury to the lens is so great that the operation is practically restricted to the class of cases last mentioned.

The best place for an artificial pupil is in the lower inner quarter of the iris, the second best in the lower outer quarter. As the portion of the cornea traversed by the knife or needle is likely to become more or less opaque in consequence, the incision in it should be made as far as possible from the point where the pupil is to be created.

Simple Incision. Cheselden, who was the first to perform this operation, entered a narrow-bladed knife through the sclerotic just anterior to the insertion of the external rectus, the point directed toward the centre of the globe of the eye. After the point had penetrated to the depth of one-eighth of an inch it was directed forward, passed through the iris to the anterior chamber and transversely across the latter, its edge looking backward. By pressing the edge against the iris and withdrawing it a horizontal incision was made in that membrane.

Bowman punctured the cornea midway between its centre and external border, passed a narrow blunt-pointed knife through the puncture into the anterior chamber, and thence through the pupil to the posterior surface of the inner half of the iris, which he then divided by cutting forward. The danger of injury to the cornea during the last step of the operation is very great.

Bell¹ uses a double-edged needle which is "introduced through the cornea near its margin; on arriving at the place where the pupil ought to be, one edge is drawn against the iris and divides it transversely, if possible, without injuring the lens."

Wecker proposes *simple iridotomy* and *double iridotomy*; the former in cases of central opacity of the cornea or lens, the latter when the pupil has become obliterated after removal of a cataract. He uses a small lance-shaped knife with a shoulder, straight or bent upon the flat, and a pair of forceps-scissors.

Simple Iridotomy (Wecker). The knife is entered midway between the centre and border of the cornea on the side opposite to that on which the pupil is to be made. As soon as the cornea has been perforated the knife is withdrawn and the forceps-scissors passed through the wound to the further border of the pupil, where they are opened and one of the blades passed behind, the other in front, of the iris. By closing them sharply the circular fibres are divided from the margin of the pupil toward the periphery of the iris. The scissors are then withdrawn, the iris replaced if it engages in the wound, a few drops of a solution of atropine placed between the eyelids, and a compress applied.

Double Iridotomy (Wecker). The knife is passed perpendicularly through the cornea and iris one millimetre from the edge of the conjunctiva, on the side toward which the obliterated pupil has been retracted; its point is then made to pass along the posterior surface of the iris until arrested by its shoulder, when it is withdrawn slowly. The forceps-scissors are next introduced through the incision, and one blade passed behind and the other in front of the iris for a distance of one-quarter of an inch or a little less. Two successive sections of the iris are then made, inclosing a triangular flap, the apex of which is directed toward the incision in the cornea. The pupil is formed by the retraction of this flap.

Iridectomy. Excision of a portion of the iris may be employed for the purpose of creating an artificial pupil

¹ Manual of surgical operations, 3d edition, p. 167

(optical iridectomy), or for the relief of tension in glaucoma or irido-choroiditis (antiphlogistic iridectomy), or as a preliminary to the removal of a cataract. The size of the portion excised is determined by the length and position of the line of the incision on the posterior surface of the cornea; the nearer this is to the margin of the cornea the larger will be the portion of the iris removed. In antiphlogistic iridectomy, therefore, when the entire breadth of the iris from the pupil to its outer margin should be removed, the knife must be entered one millimetre outside of the clear portion of the cornea; in optical iridectomy, on the other hand, the excised portion should be small and the knife should be entered within the margin of the cornea. In antiphlogistic iridectomy at least one-fourth of the iris should be removed, the piece being taken from the upper segment in order that the loss may be hidden by the upper eyelid. In optical iridectomy the pupil should be made on the inner side of the lower segment unless corneal opacities are in the way.

FIG. 159.



FIG. 160.



Operation for Antiphlogistic Iridectomy. The instruments required are a lancet-shaped knife, straight (Fig. 159) or bent (Fig. 160), iridectomy forceps (Figs. 161 and 162), and scissors curved upon the flat (Fig. 163).

The patient having been anesthetized and placed in a

recumbent posture, the surgeon takes such a position in front of or behind him as will facilitate the making of the

FIG. 161.



FIG. 162.



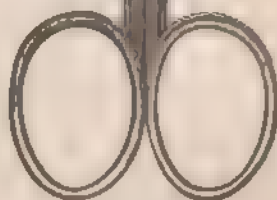
FIG. 163.



FIG. 164.



Iridectomy. Incision of cornea.



first incision. The eye-speculum and fixation forceps having been applied, the latter immediately opposite the point

of puncture, the knife is introduced perpendicularly to the surface of the sclerotic one millimetre outside of the margin of the cornea and passed steadily in until its point has entered the anterior chamber at its very rim; its direction is then changed and it is carried along the anterior surface of the iris until its point reaches the centre of the pupil, or until the length of the incision is considered sufficient (Fig. 164). By inclining the point of the knife to each side, the length of the incision in the posterior surface of the cornea may be made equal to that of the anterior surface.

The knife is then withdrawn and the aqueous humor allowed to run off very slowly in order that the relief of intra-ocular pressure may not be so sudden as to lead to congestion and hemorrhage.

If the iris does not now present in the wound the iridectomy forceps must be introduced closed as far as to the margin of the pupil, which is then seized and drawn out gently through the incision. An assistant then cuts off with the curved scissors all the protruding portion of the iris close to the lips of the wound (Fig. 165). Or the

fixation forceps may be confided to the assistant before the introduction of the iri-

FIG 165.



Iridectomy. Excision of the iris.

FIG 166



Tyrrell's hook

deotomy forceps, and the surgeon left free to use the scissors himself. Instead of the iridectomy forceps, Tyrrell's hook (Fig. 166) may

be used to draw the iris out through the incision. It must be introduced upon its side, hooked around the margin of the pupil, and then its point must be turned toward the cornea and away from the centre of the eyeball so that it will not catch upon the posterior edge of the incision during its withdrawal.

If any hemorrhage takes place into the anterior chamber

the escape of the blood before coagulation should be favored by separating the lips of the incision with a curette, and making gentle pressure upon the eyeball. The edges of the iris must be carefully replaced with a spatula and not left included in the corneal wound.

Iridesis, or displacement of the pupil by ligature. Critchett,¹ the inventor of this operation, claims that by it the size, form, and direction of the pupil can be regulated to a nicety, and its mobility preserved. It is applicable to numerous groups of cases in which the natural pupil, or even a part thereof, is movable, and has a free edge; but the simplest class is that of central opacity of the cornea, in which it is only required that the natural pupil should be moved slightly to one side, so as to bring it opposite the transparent part of the cornea. It has also been used in cases of conical cornea, to change the shape of the pupil to that of a slit; and in a case where the pupil had been rendered very small and narrow by broad synechiae, Critchett made it large and almost circular by drawing its sides apart at nearly opposite points.

The operation is performed as follows:

An opening is made with a broad needle through the margin of the cornea close to the sclerotic, and just large

FIG. 167



Iridesis

enough to admit the canula forceps. A small portion of the iris near but not close to its ciliary attachment is seized and

¹ Ophthalmic Hospital Reports vol. I. p. 220

drawn out to the extent considered sufficient for the proposed enlargement of the pupil; a piece of fine floss silk, previously tied in a small loop round the canula forceps, is slipped down, and carefully tightened around the portion of iris made to prolapse, so as to include and strangulate it (Fig. 167). This manœuvre is best accomplished by holding each end of the silk with a pair of small broad-bladed forceps, bringing them exactly to the spot where the knot is to be tied, and then drawing it moderately tight. The small portion of the iris included in the ligature speedily shrinks, leaving the little loop of silk, which may be removed on the second day.

If it is desired to make the pupil extend to the periphery of the iris, the margin of the pupil must be seized with the forceps and drawn out through the incision. In this case Soelberg Wells prefers a blunt hook to the canula forceps.

Corelysis, or rupture of adhesions uniting the margin of the pupil and the lens. The operation was first performed by Streatfield, as follows: 'He punctured the cornea with a broad needle on the outer side near its margin, passed his spatula (Fig. 168) along the anterior surface of the iris to the pupil, engaged the adhesions in the notch on the edge of the spatula, and tore them. When the entire margin of the pupil was adherent, he passed the needle along the sur-

FIG. 168.



Streatfield's spatula hook

face of the iris, across the pupil to its opposite margin, and cut the adhesions at that point. Then withdrawing the knife, he passed the spatula through the hole thus made, and easily broke up the remaining adhesions. When the adhesions were too strong to be broken with the spatula, he used the canula scissors. A few drops of a solution of atropine should be applied to the eye, both before and after the operation.

¹ Ophthalmic Hospital Reports, vol. 1, p. 6

OPERATIONS UNDERTAKEN FOR THE RELIEF OF
CATARACT.

A cataract is an opacity of the crystalline lens, or of its capsule, or of both: the former being much the more common variety. It may be hard, soft, or semiliquid, and its condition, in this respect, has an important bearing upon the choice of a method of operation. The lens is composed of a solid nucleus and a soft cortex; the whole lying free within the capsule which is itself attached to the vitreous humor. In consequence of the absence of adhesions between the lens and the capsule, moderate pressure is sufficient to force out the former after the latter has been divided.

In operating upon a cataract, the patient should be recumbent: cocaine anæsthesia is sufficient except with young children or unruly patients, when ether may be necessary. The other eye should be covered with a bandage, unless its sight is entirely lost; and an eye-speculum may be used to keep the lids apart, if the services of a trained assistant cannot be had. The objection to a speculum is that it is somewhat in the way of the knife, cannot be removed promptly enough, and is apt to make dangerous pressure upon the eye. If used, the screw of the instrument should be loosened as soon as the incision has been made. A few drops of a solution of atropine should be placed under the lids a short time before the operation.

The methods of operation may be classified as:

- Depression or couching;
- Division, discission, or solution;
- Extraction;
- Operation for secondary cataract.

Depression or couching, which was the original and, for many years, the only method of removing cataract, is now universally abandoned, on account of the danger that the displaced lens may set up inflammation of the eye by contact with the other parts, especially the iris and ciliary processes, and thus cause total loss of sight. Soelberg Wells states that about fifty per cent. of the eyes thus operated

upon have been lost by chronic irido-choroiditis. The operation will be described, however, for the sake of reference. If the puncture is made in the sclerotic, the operation is called *scleronyxis*; if in the cornea, *keratonyxis*.

Scleronyxis. A curved couching needle (Fig. 169), its convexity turned upward, is passed through the sclerotic on the temporal side about four millimetres from the margin of the cornea, and three millimetres below the horizontal diameter of the eye. Its convexity is then turned forward, and the needle carried behind and parallel to the iris, across to the upper and inner margin of the pupil (Fig. 170), when the handle is lightly tilted upward, and the lens slowly depressed by the concave surface of the needle. After holding it in place for a moment, the needle is slightly rotated to disentangle its point, and withdrawn.

Some authors recommend that the anterior capsule should be formally divided horizontally or vertically before the lens is depressed.

Fig. 169.



Couching needle

Fig. 170.



Depressing cataract.

Keratonyxis. The needle is passed through the cornea a little below its horizontal diameter, and midway between its centre and margin, and carried backward and inward, through the pupil to the lens, which is then depressed as before.

In the variety of depression called *reclination*, the upper edge of the lens is rotated backward about its transverse axis at the same time that it is depressed, so that its anterior becomes its superior surface.

Division, Discission, or Solution. The object of this operation is to tear open the anterior capsule with a fine needle, and by thus bringing the aqueous humor into contact with the lens to promote the gradual softening and absorption of the latter. The selection of the term discission was made in consequence of an erroneous impression, that the more completely the lens was broken up at first the more rapidly would the work of absorption go on, and surgeons, therefore, tried to cut the whole lens into fragments. Experience has since shown that in most cases the absorption must be gradual and the operation frequently repeated, only a small amount of the substance of the lens being

FIG. 171



Bowman's fine stop needle.

allowed to come into contact with the aqueous humor on each occasion. If the lens is all broken up at once, the numerous fragments swell and act as foreign bodies in the aqueous humor, and set up inflammation in the iris and cornea, with immediate arrest of the process of absorption. This operation is more especially indicated in the cortical cataract of children and of young persons up to the age of twenty or twenty-five years, also in those forms of lamellar cataract in which the opacity is too extensive to allow of much benefit being derived from an artificial pupil. After the age of thirty-

FIG. 172.



Hays's knife needle.

five or forty, absorption is much slower, and the iris much more irritable.

There are two methods of performing the operation ; in one the needle is passed through the cornea, in the other through the sclerotic.

Division through the Cornea. The pupil is widely dilated with atropine, the eyelids drawn apart by an assistant, or fixed with the eye speculum, and a fold of conjunctiva on the inner side of the eye seized with the fixation forceps. A fine spear-shaped needle with a shoulder (Fig. 171) is passed through the outer lower quadrant of the cornea, almost perpendicularly to its surface at a point well within the dilated pupil, so that the iris shall not be touched by the needle. One or more incisions, according to the effect desired, are then made in the anterior capsule of the lens, the needle withdrawn, and a compressive bandage applied. The operation may be repeated as soon as all redness and irritability of the eye have disappeared.

Division through the Sclerotic (Hays'). The patient having been prepared as before, the knife-needle (Fig. 172), with its cutting edge upward, is passed through the sclerotic at a point on its transverse diameter three or four millimetres from the temporal margin of the cornea, and perpendicularly to the surface of the eyeball. Its direction is then changed and its point carried between the iris and lens to the opposite margin of the pupil. If it encounters and penetrates the lens on the way, it will probably dislocate it, in which case extraction should be at once performed ; if the needle is pushed into the lens without dislocating it, the instrument should be withdrawn until its point is free, and then pushed on again in a better direction.

This being accomplished, the edge of the knife is turned back against the centre of the lens, and a free incision made by withdrawing it a short distance, while pressing its edge firmly against the cataract.

In order to expedite the cure, Wells thinks it is a good plan to combine division with extraction, and remove the whole cataract by a linear incision after it has been softened by contact with the aqueous humor. In children this may

be done within a week after the division. The same proceeding may be employed in cases of partial cataract, the transparent portion of the lens being made opaque and softened by the introduction of the needle.

Extraction. The methods of extraction may be classified as—

- The flap ;
- Von Graefe's ;
- The linear ;
- The scoop ;
- Extraction by suction ; and
- Removal of the lens in its capsule.

Flap Extraction. The common flap operation is certainly the best when it is successful. It is nearly painless, does not affect the appearance of the eye, and leaves a natural

FIG. 173



Sichel's knife.

movable pupil. These advantages, however, are offset by serious disadvantages ; the great size of the flap involves the risk of partial or diffuse suppuration of the cornea, accompanied possibly by suppurative iritis or irido-choroiditis. Prolapse of the iris is a not infrequent complication, and the after-treatment requires much more care and attention. But at present this operation is performed about as often as von Graefe's, and with the latter's knife instead of Beer's.

The instruments required are a Beer's (Fig. 158) or Sichel's (Fig 173) or von Graefe's (Fig. 177) knife, fixation forceps, Graefe's cystotome and curette (Fig. 174), and a small blunt-pointed knife or pair of scissors for enlarging the wound, if necessary.

FIG. 174

Von Graefe's
cystotome and
curette

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¹ American Journal of Medical Sciences July, 1855, p. 81

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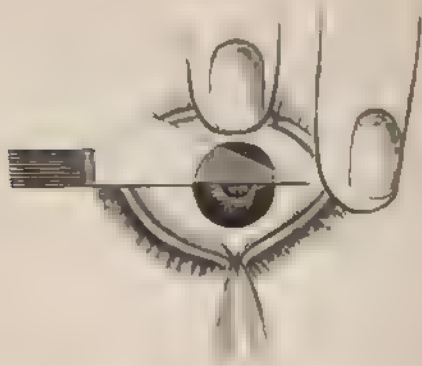
FIG. 174.

Von Graefe's
cystotome and
curette

The section may be made in the upper or lower half of the cornea ; the former is rather the more advantageous, the latter the easier of execution.

Operation. (Right eye, upper section.) *First Stage.* Patient recumbent, the operator seated behind him. The eyelids are separated by an assistant standing at the patient's left side, and drawing the lids gently apart with the forefinger of each hand, without making any pressure upon the eye. The surgeon steadies the eyeball by pinching up a fold of conjunctiva, with fixation forceps, either just below the cornea, as in Fig. 175, or better, perhaps, just below its prolonged horizontal diameter on the inner side, and

FIG. 175.



Flap extraction of cataract. Mode of fixing the eye and making the incision

draws the eyeball gently down. He then enters the point of the knife at the outer side of the cornea half a millimetre within its margin, and just on its transverse diameter, and carries it steadily across the anterior chamber, taking care to keep the side of the blade parallel to the iris, and to press slightly downward with its back so that it may always fill the incision completely and prevent the escape of the aqueous humor. The counterpuncture is made by the steady advance of the knife at a point immediately opposite that of entry, the fixation forceps removed, and the knife pushed on in the same direction until the

be done within a week after the division. The same proceeding may be employed in cases of partial cataract, the transparent portion of the lens being made opaque and softened by the introduction of the needle.

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- The flap ;
- Von Graefe's ;
- The linear ;
- The scoop ;
- Extraction by suction ; and
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FIG. 173.



Siebel's knife.

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The instruments required are a Beer's (Fig. 158) or Siebel's (Fig. 173, or von Graefe's (Fig. 177) knife, fixation forceps, Graefe's cystotome and curette (Fig. 174), and a small blunt-pointed knife or pair of scissors for enlarging the wound, if necessary.

FIG. 174.

Von Graefe's
cystotome and
curette

FIG. 177

Von Graefe's
cataract knife

FIG. 178

Iridectomy
forceps

during the passage of the lens through the pupil and the incision, must then be removed, and the eye closed.

Such was the operation employed for extraction of the ordinary, hard, senile cataract. The objections to it, as before mentioned, were the great size of the flap, the possible prolapse of the iris during the after-treatment, and the risk of iritis excited by the bruising of the iris during the passage of the lens through the pupil. Von Graefe was the first to suggest that this last risk would be diminished by the excision of a portion of the iris, iridectomy, and on putting the suggestion into practice he found that it also enabled him to remove the cataract safely through a much smaller incision. According to Mr. Carter,¹ Von Graefe worked very sedulously during several years at the endeavor to exclude, one by one, the chief sources of the dangers by which extraction was beset, and he arrived at last at the point of losing only four eyes out of one hundred operations. A few improvements in detail have been added since his death, but so far as principles and broad outlines are concerned he had covered the ground. In view of the shortness of the incision, which occupies not more than one-quarter of the periphery of the cornea, the operation is generally spoken of as a "modified linear extraction;" but the curved

outline of the incision, and the fact that the lens is removed entire, certainly bring it within the class of flap extractions.

Von Graefe's Method. Modified Linear, or Modified Flap Extraction. The instruments required, besides the eye-speculum and fixation forceps, are a long, thin, narrow knife (Fig. 177), the blade of which is thirty millimetres long and two millimetres wide, iridectomy forceps (Fig. 178), sci-sors, a cystotome (Fig. 174), and a small hard-rubber or tortoise-shell curette.

The patient is etherized and recumbent; the surgeon stands or sits behind him, holding the knife in his right hand for the right eye, in the left hand for the left eye. The eyeball is secured with the fixation forceps, and the point of the knife is entered in the sclerotic with its edge upward, one millimetre from the upper and outer margin of the cornea, and two millimetres below a tangent to its circle drawn at the upper end of its vertical diameter (Fig. 179, A). The point of the knife is at first directed toward the centre of the eyeball, but as soon as it has penetrated to the

FIG. 179.

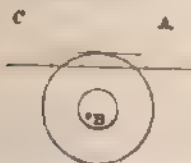


Diagram to illustrate the method of making von Graefe's incision.

FIG. 180.



Line of Von Graefe's incision.

anterior chamber it is turned so as to pass parallel to and along the anterior surface of the iris downward and inward about seven millimetres to a point corresponding to B in Fig. 179. The handle is then depressed, turning on the back of the blade in the incision, until the point is raised to the horizontal line of the puncture, when the handle must be inclined somewhat backward, and the point pushed sharply through the sclerotic and conjunctiva at C, Fig. 179. Great care must be taken not to make the counter-puncture too far back in the sclerotic, a mistake which may

easily happen if the blade is carried too far downward and inward before it is turned up to make the counter-puncture.

The edge is then directed forward, and the incision completed by steady advance and withdrawal of the knife. The incision is represented by the upper, undotted line in Fig. 180; its centre should lie at the juncture of the cornea and sclerotic. The little bridge of conjunctiva which remains at the centre of the incision is then divided in such manner as to leave a conjunctival flap two or three millimetres long adherent by its base to the cornea. If the cataract is large and hard, it may be advisable to use a broader knife, and make the points of puncture and counter-puncture one millimetre lower, so that it will not be necessary to use a scoop or make much pressure on the eye to effect the removal of the lens.

Many surgeons prefer to make the incision wholly in the cornea and close to its edge, on the ground that the wound will heal more promptly and kindly, and be accompanied by less risk of loss of the vitreous or of prolapse of the iris.

The object of the *iridectomy*, which is the next step in the operation, is the neutralization of the circular fibres

FIG. 181.

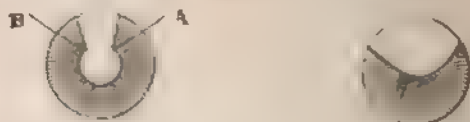


Diagram of the correct and faulty sections of the iris.

rather than the removal of a large portion of the iris, although some surgeons counsel the latter on account of the greater security it gives against subsequent inflammation. The iridectomy forceps are introduced closed, and opened slightly when the point reaches the margin of the pupil. The margin rises between the branches, is seized, withdrawn gently, and cut off with scissors close to the forceps. If this is properly done the angles formed by the edges of the incision and the margin of the pupil will appear in the anterior chamber as at *A* and *B* in Fig. 181.

The portion of iris removed should extend quite to its ciliary insertion so that there may be none to engage in the external incision and prevent its primary union.

The capsule is next freely divided by two successive lacerations made with the cystotome. Each should begin at the lower edge of the pupil and extend upward, one along the inner, the other along the outer side, to the upper border of the lens, where it has been exposed by the iridectomy. This upper border should also be torn to an extent corresponding to the external incision. This manoeuvre must be executed with great delicacy and lightness of touch, in order that the lens may not be displaced into the vitreous humor.

The escape of the lens is aided by pressure upon the cornea with the curette. The fixation forceps are applied at the inner or outer side, and the curette placed upon the lower edge of the cornea and pressed slightly backward and upward so as to cause the upper edge of the lens to present in the section; the pressure must then be made directly backward, in order that the lens may be rotated around its transverse axis and tilted well forward into the incision. The curette is then pushed slowly upward over the surface of the cornea so as to follow step by step the delivery of the lens. Any fragments scraped off during the passage may be removed by passing the curette again over the surface of the cornea.

If the vitreous humor happens to be liquid it may escape as soon as the first incision is made. In such a case it is best to excise a portion of the iris and remove the lens in its capsule by passing a scoop behind it into the vitreous humor and lifting it out.

Gayet and Knapp's Modification. Instead of lacerating the capsule as above described these surgeons incise it with a knife-needle along the line of the corneal incision. This is followed in the great majority of cases by an unusually uneventful healing free from iritis and other complications, but leaves the pupillary area occupied by the capsule of the lens. In order to clear the pupil the capsule is subsequently (in the third week after the extraction, or later) split with the knife-needle, which permanently

frees the pupil from both the anterior and posterior capsules.

Linear Extraction. Mr. Dixon suggests¹ *rectilinear extraction* as a more suitable name, because the incision in the cornea is a straight one, in contradistinction to that of a flap extraction which also forms a line, but a curved one. This operation is a modification of one invented by Gibson in 1811, which had fallen into entire disuse before its reintroduction by Von Graefe in 1855. It is designed for the removal of soft cataracts through a small corneal incision, especially the cortical cataract of individuals between ten and thirty years of age. It is also often employed with advantage as supplementary to the needle operation. It is performed as follows:

A straight, vertical incision, from four to six millimetres long, is made on the outer side of the cornea, about two millimetres within its margin, with a straight lance-shaped iridectomy knife, which is passed into the anterior chamber parallel to the surface of the iris. The capsule is then freely lacerated with the cystotome, and the escape of the soft lens facilitated by the introduction of a curette into the wound, and by making gentle pressure on the inner side of the eye with the finger. If portions of the cortex

FIG. 182.



Crichton's scoops.

FIG. 183.



Bowman's scoops.

FIG. 184.



remain behind the iris they can be brought into the anterior chamber by closing the lids and making gentle pressure in circular lines upon them. If the iris protrudes, it must be gently replaced, or, if much bruised, excised.

Senop Extraction. This is a modification of linear extraction, devised by Waldau to obviate the dangers and dif-

sculties occasioned by the presence in the lens of a hard nucleus of greater or less size. As the principal danger lies in the bruising of the iris, Von Graefe met it by iridectomy, which afterward suggested to Waldau the idea of introducing a scoop and removing the lens without making any pressure upon the eyeball.

The instruments required are a bent lance-shaped iridectomy knife (Fig. 160), iridectomy forceps and scissors, and a thin, flat, slightly concave scoop. Waldau's scoop resembled a small spoon. Three different kinds are shown in Figs. 182, 183, 184.

The eye-speculum and fixation forceps having been applied, an incision, eight or nine millimetres long, is made at the upper border of the cornea where it joins the sclerotic. The corresponding portion of the iris is removed, and the capsule freely torn with the cystotome, as before described.

The scoop, with its convexity backward, is then introduced and carried carefully down behind the lens, until its extremity has passed the lower margin of the latter, and engaged it in its hook-like end. It is then withdrawn, care being taken not to press the lens against the iris and cornea. If a little of the vitreous humor escapes at the same time, it must be snipped off

FIG. 185.



Curette and mouthpiece for removal of cataract by section.

and a compress applied. It is better to remove any fragments of the lens that may be left behind by gently rubbing the eyeball, rather than reintroducing the scoop.

Removal by Suction. Laugier suggested, in 1847, the removal of soft cataracts by aspiration through a hollow needle. Blanchot modified the method by substituting a small cannula for the needle, and introducing it through an incision in the cornea, but the operation was not favorably received until after it had been again modified by T. Pridgin Teale, Jr., in 1863, who recommended it as a substitute for pressure in the removal of the harder portions of the cataract by linear extraction, and as supplementary to dissection. The instruments required are a broad needle and a suction curette. The latter (Fig. 185) is described by Mr. Teale¹ as consisting of three parts, a curette, handle, and suction tube. "The curette is of the size of the ordinary curette, but differs from it in being rooted in to within one line of its extremity, thus forming a tube flattened on its upper surface, and terminating, as it were, in a small cup.

The anterior capsule is first ruptured with a fine needle passed through the cornea, and then an opening is made with a broad needle in the cornea through which the curette is passed to the centre of the pupil. The soft matter is then withdrawn by suction.

Noelberg Wells² says this operation has been employed at the Royal London Ophthalmic Hospital with great success, and that it is especially indicated in cases of soft cortical cataract. If the cataract is somewhat harder, it is well to break it up with the needle a few days before attempting to remove it.

Removal of the Lens in its Capsule. This operation is indicated when the capsule is opaque, and whenever the eye is exceptionally irritable, or has been chronically inflamed, so that the accidental retention of any fragments of the lens would be a source of serious danger. When suc-

¹ Ophthalmic Hospital Reports, vol. IV, part 2, p. 187.

² On the Diseases of the Eye, p. 280. Philadelphia: H. C. Lea.

cessful, this method gives very fine results, but its risks and dangers are so great that it is seldom employed. Originally introduced by Richter and Beer, it was revived by Sperino, Pagenstecher, and Wecker. The former employed the ordinary flap operation without laceration of the capsule. Pagenstecher made a large flap in the sclerotic together with iridectomy. Wecker's method was nearly identical, the incision being made at the sclero-corneal junction.

Pagenstecher's Method. The patient having been thoroughly anesthetized, a large flap is made, usually downward, with a Beer's knife, a small bridge of conjunctiva being left temporarily at its apex. Iridectomy is then performed in the outer lower quadrant, and the conjunctival bridge divided with blunt-pointed scissors. Any posterior synechie that may exist are torn through with a fine silver hook, and then the lens removed in its capsule by slight pressure upon the eyeball. If the hyaloid membrane should be ruptured and the vitreous escape, the lens must be removed with the aid of a small scoop passed in behind its lower edge.

Secondary Cataract. Secondary cataracts vary much in thickness and opacity. They may be produced by portions of the lens left behind and becoming entangled in the capsule, by the deposit of lymph upon the latter, or by the proliferation of the intracapsular cells. No operation for secondary cataract should be performed, until, at least, three or four months after the removal of the primary cataract; and if the pupil has become contracted, or if very extensive posterior synechie have formed, a preliminary iridectomy should be made. Formerly the plan was to remove the opaque and thickened membrane entirely from the eye, but it has proved very much safer and equally efficacious to make a small opening in the membrane with a needle.

Cocaine anesthesia is necessary. The eye speculum and fixation forceps having been applied, Bowman's fine needle (Fig. 171) is passed through the cornea near its margin, and an effort made to tear a hole with it in the centre of the membrane or at the part which is thinnest and least opaque.

If the membrane yields before the needle, or if it is too tough to be torn, Mr. Bowman's device of a second needle must be employed. This is to be passed through the cornea on the side opposite to that occupied by the first needle, and then the operator, transfixing and steadying the membrane with one needle, tears it with the other. If any portion of the iris should happen to be bruised or torn, it must be excised through a linear excision.

Dr. Agnew passes a needle through the centre of the membrane, thus steadying both it and the eye. He then makes a linear incision on the temporal side of the cornea through which he passes a small sharp pointed hook, the point of which is passed into the same opening in the membrane as the needle. He next tears the membrane, rolls it up about the hook, and either draws it out altogether, or, if this cannot be done, tears it widely open.

OPERATION TO CORRECT STRABISMUS—STRABOTOMY.

The tendon of the internal rectus is attached to the sclerotic at a distance of five millimetres from the border of the cornea, that of the external rectus at a distance of seven millimetres. Each tendon is seven or eight millimetres broad and is contained in a firm sheath resembling a glove finger, a prolongation or depression of the capsule of Tenon at the point where it is traversed by the tendon about midway between the anterior margin of the orbit and the posterior pole of the eyeball. The capsule of Tenon is a reflection of the periosteum of the orbit from the anterior margin of the latter to the transverse meridian of the eyeball and thence backward to and along the optic nerve, thus constituting a diaphragm which divides the orbit into an anterior and a posterior loge, the former of which contains the eyeball (received into a cup-like depression of the diaphragm), the latter the muscles and optic nerve. The capsule sends a prolongation, not only anteriorly along the tendons, but also posteriorly along the muscles, and the union between the muscle and sheath is so firm that even after division of the tendon the muscle can move the eyeball by acting through the attachments of the capsule. If

the body of the muscle itself is divided in the posterior lobe, its influence upon the movements of the eyeball is entirely lost. This is the chief point to be borne in mind in performing strabotomy, the tendon must be divided, not the muscle, and the amount of deviation of the eye to be overcome is the measure of the extent to which the adjoining tissues must be divided.

The Operation for Division of the Internal Rectus will alone be described, that being the one commonly required. The special instruments required are: fine-toothed forceps (Fig. 186), blunt hook (Fig. 187), and blunt-pointed scissors, straight or curved on the flat.

A small but deep fold of conjunctiva and subconjunctival tissue is seized with the toothed forceps just above the lower extremity of the line of insertion of tendon of the

FIG. 186.



FIG. 187.



internal rectus, that is, two millimetres below a point on the equator of the eyeball five millimetres beyond the inner margin of the cornea, and divided with the scissors just below the forceps; additional snips are made with the scissors within this opening until the tendon or the sclerotic is exposed. The surgeon then passes the point of the strabotomy hook, which should be somewhat bulbous, through the opening to the lower border of the tendon, and, keeping the point and side of the hook constantly upon the sclerotic, sweeps it at first backward, and then upward and forward around the insertion. When this manœuvre is properly executed, the point of the hook can be seen under the conjunctiva above the upper border of the tendon, while its

course is hidden by the latter and prevented from being drawn forward to the margin of the cornea. If the whole of the hook can be seen under the conjunctiva, it is not under the tendon, and the sweep must be repeated. When the tendon has been secured, the conjunctiva may be pressed back over its point, and the tendon divided with scissors close to its insertion, beginning at its upper border; or, the conjunctiva being left in place, the scissors may be passed along the hook as a guide, one blade below the tendon, the other between it and the conjunctiva, and the tendon divided with repeated snips.

After the tendon has been completely cut through, the hook should be swept upward and downward to ascertain if the lateral expansions of the tendon have been divided, for the persistence of even a few of them might be sufficient to prevent the success of the operation.

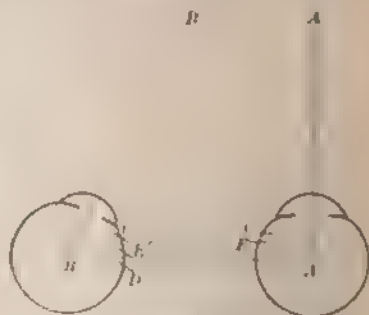
If it is feared that too great an effect has been produced, a deep suture may be passed through the tendon and the conjunctiva on the side toward the cornea so as to limit the

FIG. 189



Method of estimating the degree of squint.

FIG. 190



Double operation for strabismus.

amount of retraction. The accommodative movements of the eye should be tested immediately after the operation, and if there is the slightest tendency to divergence when the object is six or eight inches distant from the eye a suture should be inserted.

In the *subconjunctival method* the incision in the conjunc-

tiva is made below the insertion of the tendon on a line with the lower border of the cornea, and the conjunctiva is not pressed away from the anterior surface of the tendon after the hook has been passed under the latter.

If the squint exceeds five or six millimetres, as estimated by the method shown in Fig. 188, both eyes should be operated upon, but at separate times, the insertion of the internal rectus being set back in each case. Thus, if the degree of squint represented in Fig. 189 were corrected by setting back the tendon of the internal rectus from *C'* to *D*, the muscle could only work at a great disadvantage as compared with the internal rectus of the other side, and the result would be the appearance of divergent squint whenever the attempt was made to look at an object near the eye, because the muscle could not turn the eye far enough inward. The condition must therefore be divided between the two eyes, the internal rectus on one side being set back to *E*, on the other side to *E'*.

Secondary Strabismus following Tenotomy of the opponent is treated by advancing the insertion of the tendon of the latter (*Protraphy*). Thus, supposing divergent squint to have followed division of the internal rectus, an incision half an inch long is made in the conjunctiva in the line of the horizontal diameter of the cornea, and the conjunctiva and subconjunctival tissue dissected up as far back as to the caruncle. A hook is then passed around the insertion of the internal rectus, and the tendon divided as before; a suture is passed through it, and it is drawn toward, and fastened to, the strip of conjunctiva adjoining the inner border of the cornea. The tendon of the external rectus must then be divided according to the rules laid down for division of the internal rectus, remembering that its attachment to the sclerotic is distant seven millimetres from the edge of the cornea.

ENUCLEATION OF THE EYEBALL.

As the globe of the eye lies somewhat nearer the inner than the outer side of the orbit, it will be found easier to

approach it from the latter quarter. Tillaux¹ divides the conjunctiva and subconjunctival fascia with curved scissors along the attachment of the external rectus, divides the tendon of that muscle, carries the scissors backward through the incision, their concavity turned toward the globe, and cuts the optic nerve close to the eyeball. He then seizes the posterior pole of the globe with pronged forceps, draws it out through the conjunctival incision, and divides the remaining conjunctival attachments and tendons close to the sclerotic.

Other surgeons prefer to seek and divide each tendon in turn before cutting the optic nerve.

Extirpation of the Entire Contents of the Orbit. In order to gain additional room, it is well first to divide the external commissure of the lids. A bistoury is then entered at the inner angle, carried well back toward the apex of the orbit, and swept along the floor to the outer angle, then reintroduced at the inner angle, and carried along the roof of the orbit to the outer angle. The muscles and optic nerve, which still remain attached to the eye and apex of the orbit, are finally divided with curved scissors introduced from the outer side.

Hemorrhage should be arrested by packing the cavity with antiseptic gauze.

OPERATIONS UPON THE LACHRYMAL APPARATUS.

Extirpation of the Lachrymal Gland (Fig. 190). The principal portion of the lachrymal gland lies just behind the junction of the upper and outer margins of the orbit, enveloped in a fibrous capsule formed by a reflection of the periosteum or capsule of Tenon. The "accessory" portion, together with the ducts, occupies the adjoining eyelid, and is composed of isolated granulations of granular tissue, which, if left behind after removal of the main portion, may continue to secrete tears and discharge them into the wound, thus causing abscesses and fistulae.

Tillaux² has pointed out that the existence of the fibrous

¹ Anatomie Topographique, p. 170.

² Anatomie Topographique, p. 257.

capsule renders it possible to enucleate the gland without opening the posterior lobe of the orbit, a defect in the older methods which included division of the external commissure. Make an incision one inch in length along the upper and outer portion of the bony margin of the orbit. Carry this incision through all the soft parts, including the periosteum, down to the bone; separate the periosteum from the bone at the under side of the incision, and depress it. The

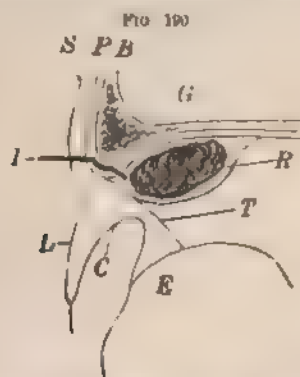


FIG. 190
S P B
 Extirpation of the lacrimal gland. *S* Skin. *P* Periosteum. *B* Frontal bone. *G* Lacrimal gland. *T* Capsule of Tenon. *R* Reflected periosteum forming the capsule of the gland. *E* Eyeball. *C* Conjunctiva. *L* Eyelid. *I* Incision.

gland can then be distinctly seen through the thin layer of periosteum which separates it from the roof of the orbit, and can be removed with great ease after the latter has been torn through.

Lacrimal Sac, Duct, and Canaliculi. The lower canaliculus passes downward from the punctum for two millimetres, then turns at a right angle, and passes horizontally inward to the lacrimal sac, a distance of about five millimetres; the upper canaliculus passes at first upward for two millimetres, and then downward and inward to the sac. This sharp turn in the course of the canaliculus, which is an obstacle to catheterization, can be temporarily removed by drawing the border of the lid outward. The lacrimal sac lies just behind the tendo oculi, and receives the cana-

FIG 191



sharp-pointed
canaliculor

FIG 192



Bowman's probe—
pointed canaliculor
for knife

liculi by a common duct two or three millimetres below its upper extremity, their relations thus resembling those of the ileum and cæcum, a resemblance which is increased by the presence of a valve at the opening of the duct into the sac. This valve, described by Huschka, is thought to prevent the reflux of the contents of the sac into the canaliculi. The direction of the sac is downward and backward at an angle of 45° ; it occupies the lacrymal groove, which is bounded anteriorly by a ridge on the nasal process of the superior maxillary bone at the inner angle of the orbit, and is crossed by the tendo oculi just at the junction of its upper and middle thirds. The nasal duct is the direct continuation of the sac and passes downward, backward, and outward; the combined length of the duct and sac is about one inch.

It may become necessary to *slit up the canaliculus* in order to correct a malposition of the punctum, or to facilitate catheterization of the sac and nasal duct. This little operation is best performed as follows (right eye, lower lid): The surgeon stands behind the patient, who is recumbent, and introduces a fine grooved director (Fig. 191) vertically through the punctum for a distance of two milli-

metres. Then drawing the border of the lid outward and somewhat downward with the forefinger of his left hand, he passes the director horizontally, with its groove upward, along the canaliculus to the inner side of the sac. Then, shifting the director to the left hand, he engages a sharp-pointed knife in the groove, and slits up the canaliculus throughout its entire length.

Bowman's probe-pointed canaliculus knife (Fig. 192) may be substituted for the director and knife. It should be very narrow, and its probe point very small.

When one punctum has been entirely obliterated, a plan suggested by Mr. Streatfeild may be employed. He divides the other canaliculus, passes a fine director, suitably bent, through the wound into the obliterated canaliculus and cuts down upon it.

If the divided lower canaliculus remains everted, Mr. Critchett advises that the posterior lip of the incision be cut off with scissors, "effecting the treble object of drawing the canal further inward, of forming a reservoir into which the tears may run, and of preventing reunion of the parts."

Puncture of the Sac (Fig. 193) The three guides are the tendo oculi, the anterior margin of the lachrymal groove,

FIG. 193.



Puncture of the lachrymal sac.

and the direction of the sac. While an assistant draws the external commissure outward, so as to make the tendo oculi tense and plainly visible, the surgeon places his left fore-

296

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SPECIAL OPERATIONS.

INTRODUCTION OF SPECULUM (ROOSA)

The upper portion of the auricle is grasped by the index and middle fingers of the left hand and drawn forward and backward. Into the canal thus situated the speculum is introduced with the right hand held in place with the thumb and forefinger of the left hand being steadied by resting its ulnar border against the patient's head. Complete control of the speculum is gained, and it can be easily moved about so as to bring any part of the tympanum and canal into view. It can be thrown into it from a concave mirror placed at the centre and having a focal distance of six inches.

MYOTOMY OF THE MEMBRANA TYMPANI (ROOSA)

This should be performed while the head of the patient is supported and a good light is thrown upon the ear by a mirror attached to a forehead band. The incision is made with the instrument usually employed, and the operation should be made in the posterior inferior quadrant.

Wells¹ calls attention to the fact that all the incisions of the membrane occupy its upper half and are liable to rise to trouble near the handle of the hammer. The lower half is less troublesome and even dangerous because it is less vascular and less sensitive. If it is desired to maintain the opening for several years, a special incision may be made, or a triangular flap may be made, as a rule, even these incisions heal very quickly.

CATHETERIZATION OF THE EUSTACHIAN TUBE

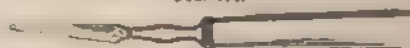
The Eustachian tube is from one and a half to two inches long, its course is from the pharynx upward, backward. Its pharyngeal orifice is oval and we

¹ *Treatise on the Diseases of the Ear*, p. 246.
² *Anatomie Topographique*, p. 111.

finger upon the inner and lower margin of the orbit, so as to have the bony edge between the nail and the pulp of the finger, and holding the knife in the direction of the canal, that is, nearly parallel to the median plane, and at an angle of 45° with the horizon, he passes it along his finger-nail into the sac just below the tendon. It is important to mark the position of the anterior margin of the canal, so as to avoid the not infrequent mistake of passing the knife entirely outside of the orbit between the soft parts of the face and the bone.

Stricture of the Nasal Duct. Division. Dr. Stilling, of Cassel, proposes to treat stricture of the nasal duct by internal division. He divides the canaliculus and ascer-

FIG. 194.



Stilling's knife.

tains the seat of the stricture with a probe, passes his knife (Fig. 194) through it, and divides it in three or four directions.

CHAPTER II.

OPERATIONS UPON THE EAR AND ITS APPENDAGES.

OCCCLUSION OF EXTERNAL AUDITORY CANAL.

CONGENITAL occlusion of the external meatus is usually associated with absence or defective development of the other portions of the auditory apparatus. Before operating upon such an occlusion, therefore, the hearing power should be tested, and the permeability or impermeability of the bony portion of the canal determined by puncture with a needle.

If the occlusion consists of a simple membranous diaphragm it should be divided crucially, and the flaps excised. For deeper and more extensive obstructions cauterization with nitrate of silver is to be preferred.

INTRODUCTION OF SPECULUM (ROOSA).

The upper portion of the auricle is grasped between the ring and middle fingers of the left hand and drawn gently upward and backward. Into the canal thus straightened the speculum is introduced with the right hand, and then held in place with the thumb and forefinger of the left, the hand being steadied by resting its ulnar border against the patient's head. Complete control of the speculum is thus obtained, and it can be easily moved about so as to bring every part of the tympanum and canal into view. Light should be thrown into it from a concave mirror perforated in the centre and having a focal distance of six inches.

PARACENTESIS OF THE MEMBRANA TYMPANI (ROOSA).¹

This should be performed while the head of the patient is well supported and a good light is thrown upon the membrane by a mirror attached to a forehead band. A cataract needle is the instrument usually employed, and the opening should be made in the posterior inferior quadrant of the membrane.

Tillaux² calls attention to the fact that all the important elements of the membrane occupy its upper half, and that an incision or rupture near the handle of the hammer may give rise to troublesome and even dangerous hemorrhage. The lower half is less vascular and less sensitive.

If it is desired to maintain the opening for several days, a crucial incision may be made, or a triangular flap excised, but, as a rule, even these incisions heal very quickly.

CATHETERIZATION OF THE EUSTACHIAN TUBE.

The Eustachian tube is from one and a half to two inches long, its course is from the pharynx upward, backward, and outward. Its pharyngeal orifice is oval and well marked

¹ Treatise on the Diseases of the Ear, p. 246

² Anatomie Topographique, p. 111

except on the lower border, and is situated just above the base of the soft palate. Behind the orifice, between it and the posterior wall of the pharynx, is a depression (Rosenmüller's fossette) in which the beak of the catheter, if carried too far back, may lodge and give the same sensation to the surgeon's hand as if it were engaged in the tube. Of the two mistakes most frequently made in performing catheterization, one is to pass the beak of the instrument between the middle and inferior turbinated bones instead of along the floor of the nasal fossa, and the other is to mistake Rosenmüller's fossette for the orifice. According to Roosa,¹ the first mistake is best avoided by drawing down the patient's upper lip with the left hand, and entering the catheter while it is held in an almost vertical position, its concavity directed toward the median line. After the beak has fairly entered the meatus the stem of the catheter is gradually raised to the horizontal position and passed backward, its beak resting on the floor of the meatus close to the septum, its convexity upward.

Tillaux² gives the following directions for finding the orifice: 1st. Carry the catheter directly backward, its concavity downward, until it touches the posterior wall of the pharynx. 2d. Withdraw it until the beak rests again upon the hard palate. 3d. Carry the catheter again very gently backward, and feel with its beak for the posterior border of the palatine aponeurosis, the firm fibrous continuation of the palatal bone. This aponeurosis feels as hard as bone, and its posterior border can be easily recognized by the softness of the adjoining tissues. 4th. Rotate the beak of the catheter outward and upward, and it will enter the Eustachian tube.

OPENING OF THE MASTOID ANTRUM.³

The incision begins just above the apex of the mastoid process and is carried upward one and one-half inches parallel to the attachment of the ear, and about one half an inch behind it. Everything is divided down to the bone, the periosteum elevated, and the posterior margin of the meatus

¹ *Diseases of the Ear*, p. 94.

² *Anatomie Topographique*, p. 140.

³ *Birmingham Dub Journ. Med. Sci.* 1892, p. 11.

recognized. A one-quarter-inch drill or gouge is driven *straight inward* at such a point that the hole it makes shall lie as near as possible to the back of the bony meatus and its upper border be not more than one-twelfth of an inch above the level of the upper margin of the meatus. It must not penetrate deeper than three-quarters of an inch or the external semicircular canal will be damaged. Deep perforations back of a line one-quarter of an inch behind the posterior margin of the meatus are liable to wound the lateral sinus. The antrum, which is about the size of a pea, is usually reached at a depth of three-fifths of an inch. The opening thus made into it may afterward be enlarged and any necrosis carefully gouged out, and the wound is finally packed and drained.

*Stucke's Method.*¹ An incision penetrating to the bone throughout is made parallel to and close behind the attachment of the auricle to the head, starting from the apex of the mastoid process and terminating well above and in front of the ear on the temporal region. The soft parts and periosteum are elevated toward the external meatus and the bony margin of the latter thus exposed. The funnel of skin, periosteum, and cartilage leading into the meatus is then still further detached with a fine elevator and cut across just external to the membrana tympani, thus exposing the whole of the bony passage. The malleus, incus, and tympanum, or its remains, are next excised, and the outer surface of the mastoid, together with the posterior wall of the external meatus and middle ear, are chiselled through, making a gutter extending from the top of the tympanic cavity to the floor of the aditus ad antrum. The chorda tympani is inevitably divided, but the facial nerve and the labyrinth are avoided by carefully keeping external to the inner wall of the tympanic cavity. After scraping out all diseased tissue the funnel of skin and periosteum, which was detached from the external meatus, is split in its long axis posteriorly and the flaps fitted into the bony gutter, thus partially providing an epidermic covering for the denuded surfaces. A couple of sutures in the extremities of the incision and an iodoform-gauze packing complete the operation.

¹ Berlin klin. Wochenschr., 1872, p. 63.

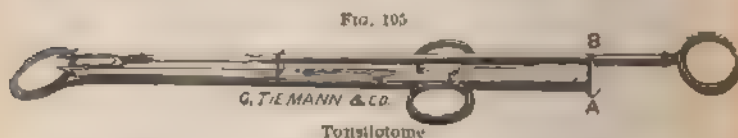
CHAPTER III.

OPERATIONS UPON THE MOUTH AND PHARYNX.

EXCISION OF THE TONSILS (AMYGDALOTOMY).

THE tonsils may be excised with a knife and volsella, or with a specially contrived instrument, the tonsilotome or guillotine.

ANÆSTHESIA is not required. If the patient is young or nervous it is well to put a large piece of cork between the



jaws on each side to prevent the mouth from being closed. The tonsilotome (Fig. 105) is composed of two rings and a fork mounted upon stems so arranged that they can be worked with the thumb and fingers of one hand. The two rings slide flatwise upon each other, and the inner edge of one is sharp, so that when drawn across the other it divides anything lying within it. The fork is thrust forward across the ring and drawn away vertically from it by the same movement which draws one ring across the other. The rings having been placed over the tonsil, the hook is driven into the latter by a quick movement of the thumb and finger and draws it further into the ring, holding it tense as the other blade cuts across its base. The pain is very slight.

If the tonsilotome cannot be used the tonsil must be seized with pronged forceps, and excised between them and the pillars with a probe-pointed knife, the posterior portion of the blade being guarded with diachylon plaster so as to avoid injury to the tongue.

STAPHYLORAPHY.

At the conclusion of his historical account of this operation Verneuil¹ states that it has been invented four different times. The earliest record of the operation is found in a French book published in 1786,² in which it is said that a dentist, named Lemonnier, closed a fissure of both hard and soft palates by freshening its edges with a knife and bringing them together with sutures. He also closed perforations of the hard palate by exciting suppuration of their borders.

In 1799 Eustache, a physician of Beziers, proposed to reunite by sutures the edges of an incision which he had made the day before in the soft palate of a patient for the purpose of removing a pharyngeal polyp. The patient refused the operation. Four years later, in 1803, Eustache sent to the Académie Royale de Chirurgie at Paris a remarkable paper upon congenital fissures in the soft palate, and asked the Society's approval of the operation by which he proposed to close them. The approval was withheld, and there is no record of any further steps having been taken.

In December, 1816, Von Graefe said, before the Medico-Chirurgical Society of Berlin, that, after many unsuccessful attempts to close fissures of the soft palate, he had at last succeeded by drawing the edges together with sutures after freshening them by applying muriatic acid and the tincture of caustarides. This remark was reported in the proceedings of the Society in *Hufeland's Journal*, January, 1817. Between 1816 and 1820 Von Graefe repeated the operation three times, each time without success.

In 1819, Roux, apparently in entire ignorance of Von Graefe's attempt, closed a fissure by paring the edges and applying sutures. The case at once became very widely known, and had much influence in popularizing the operation.

When the extent of the lesion which staphyloraphy is designed to repair is considered, the operation seems to be very simple. It is only necessary to freshen the edges of

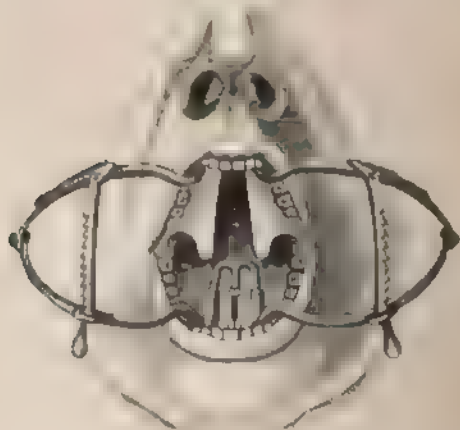
¹ *Chirurgie Réparatrice*, 1877. Art. Staphylorrhaphie.

² *Traité des Principaux objets de Médecine*, par Robert.

the gap and draw them together with sutures. Practically, however, the operation is a difficult one; the parts lie at a considerable distance from the surface, the manipulations are constantly interfered with by involuntary movements of deglutition, the flow of blood increases the obscurity, and the practical difficulties in the way of placing the sutures are great. Finally, unless some of the muscles of the palate are divided, the tension exerted by them upon the sutures is sufficient to prevent union.

A great variety of methods have been suggested to overcome these difficulties. Mr. T. Smith diminished the first by the invention of a gag (Fig. 196), designed to hold the

FIG. 196.



Whitehead's modification of Smith's gag

jaws apart during the operation. Prof. Van Buren prevented the passage of blood into the trachea during the employment of anaesthesia by placing the patient so that the head should hang down over the end of the table, and the blood escape through the nose. The same device was afterward employed by Trélat.

Sir William Ferguson relieved the tension by dividing the levator palati on each side. He did this by passing a knife, bent at a right angle, through the cleft and dividing

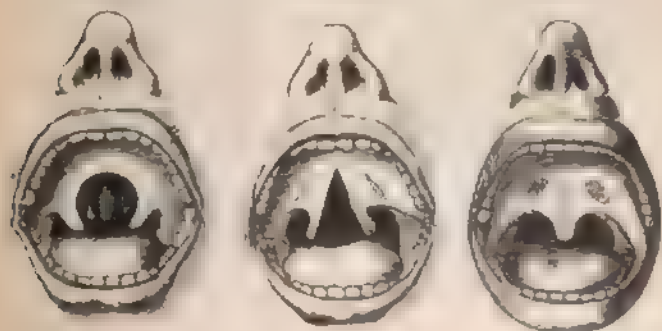
the muscle from behind forward, without touching the mucous membrane on the anterior face of the palate. The incision should be perpendicular to the centre of a line joining the hamular process and the orifice of the Eustachian tube. The former can be readily felt just behind the last upper molar tooth, the latter can usually be seen through the cleft in the palate. He also recommended division of the palato-pharyngeus muscle.

Sédillot¹ divided the muscle from before backward. He drew the velum downward and inward with pronged forceps, and made an incision downward and outward about one centimetre above and on the outer side of the base of the uvula, and just behind and on the inner side of the last upper molar, crossing the levator palati at right angles (Fig. 198). A length of one centimetre is usually sufficient, but it must be increased if the muscular contractions persist. The relaxation of the parts produced by these incisions is shown by a comparison of Figs. 197 and 199. Unless the incisions are exceptionally large their sides re-

FIG. 197

FIG. 198

FIG. 199



main in contact; in any case they promptly reunite. He then divided the anterior and posterior pillars, seizing each in turn near its centre with pronged forceps, and cutting it with scissors.

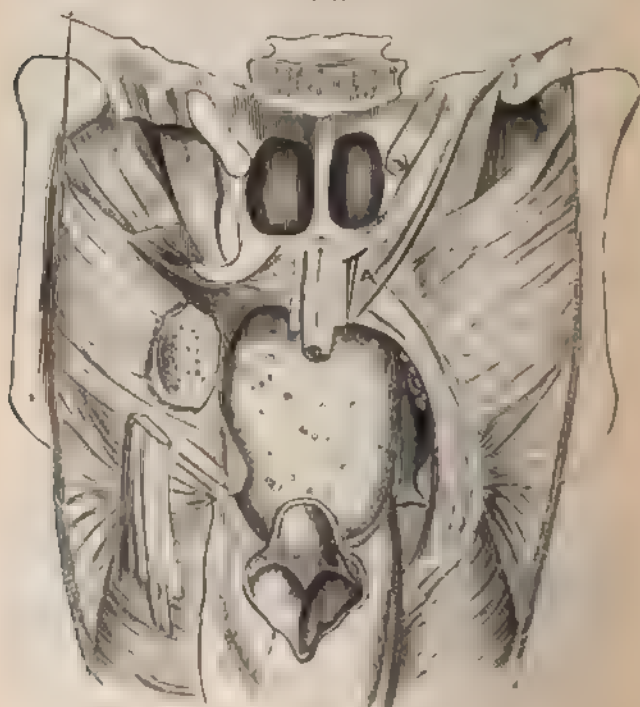
Mr. George Pollock² has modified this slightly by making

¹ *Médecine Opératoire*, vol. 1, p. 45.

² *Holmes's System of Surgery*, vol. ix, p. 426.

the incision on the anterior surface of the palate smaller. One of the halves of the palate is drawn toward the median line by means of a ligature passed through it near the base of the uvula, and a thin, narrow knife is entered close to the hamular process, a little in front of it and on its inner side, and its point carried upward, backward, and some-

FIG. 200.



Division of muscles of soft palate.

what inward, until it can be seen through the cleft, having divided on its way part, if not all, of the tendon of the tensor palati. The blade now lies above most of the fibres of the levator (Fig. 200), and by raising the handle and cutting downward, as the knife is withdrawn, an incision of considerable length, including the greater portion of the

levator, is made on the posterior surface of the palate, while that on the anterior surface need not be greater than the breadth of the knife. If the muscle has been effectually divided the palate will be pendulous and flaccid, and will not contract spasmodically when pulled upon. If any resistance should persist the knife must be introduced again through the wound and the incision enlarged downward.

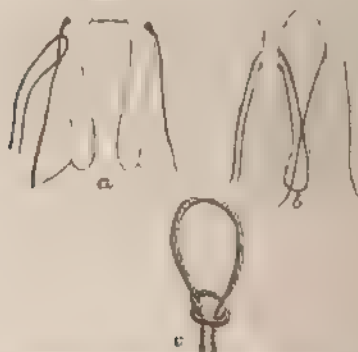
Roux placed his sutures by putting a needle at each end of the thread, and passing them from behind forward. Trélat used a needle fixed upon a long handle, the point bearing the eye and curved in the form of a U. After having been threaded the point of the needle was passed through the palate from behind forward, the thread was drawn through with a hook or forceps, and the needle, still threaded, withdrawn and passed in the same manner on the opposite side. The objection to these and to all other methods in which the needle is passed from behind forward, is that, since the point cannot be seen, it is very difficult to make the punctures on one side correspond properly with those on the other. If silk sutures are used each end may be passed from before backward, the two tied together loosely, and the knot pulled back through one of the punctures, thus bringing the loop behind the palate.

The method now usually employed is the one introduced by Bérard. A curved needle fixed on a long handle is threaded with a ligature three feet long, and its point passed through the palate from before backward; the thread is caught with hook or forceps on the posterior side, and its end drawn out through the mouth, the needle is then withdrawn and slipped off the thread. It is next threaded with a second ligature and passed in the same manner through the opposite half of the plate, the loop seized as before, drawn through a short distance, and held while the needle is withdrawn, leaving the thread double in the puncture—the loop behind the palate, the two ends in front. The posterior end of the first ligature is then passed through the loop of the second one (Fig. 201, *b*), and, by the withdrawal of the latter, drawn through the second puncture (Fig. 201, *a*). Instead of using the same needle to pass both ligatures, it is more convenient to have two curved spirally in the opposite directions, one for each side.

If silver sutures are used, thread loops should be passed from before backward on each side, one end of the wire engaged in each and drawn through.

After a suture has been passed, the ends should be brought out through the mouth, and tied together for safety. When all have been passed, the anterior one is drawn upon to bring the edges of the cleft together, and the knot tied.

FIG. 201



Staphyloraphy: passing the suture.

The knot may be an ordinary square one, an assistant holding the first twist with dressing forceps until the second is made, or it may be a noose, as shown in Fig. 201, c, secured by a second knot. If silver wire is used, it may be fastened by twisting it, or by clamping a small lead button upon it. Verneuil first passes the ends of the wire through the eyes of a shirt button, and then ties or twists. He thinks this favors more accurate adjustment of the edges, and facilitates removal of the wire.

The edges of the cleft are pared by seizing the tip of the uvula with toothed forceps, making it tense, entering the point of a narrow-bladed knife one or two millimetres back from the edge, and cutting down to the tip; then turning the knife and cutting up to the anterior angle of the cleft. Care should be taken to do this thoroughly. When the cleft is very short (bifid uvula), Nélaton employed the method

already described under his name for single uncomplicated harelip. The flaps were left adherent to each other at the apex (angle of the cleft) and to the uvula at their bases, turned down, and the raw surfaces drawn together. When the cleft was too long for this he separated the flaps at the apex, shortened them by trimming off the free ends, turned them down, and united as before.

There is no settled rule of practice establishing the order in which the different steps of the operation shall be executed, except that most surgeons are agreed upon the advisability of paring the edges of the cleft before passing the sutures. Mr. Callender recommended that the muscles should be divided a day or two before the attempt to close the cleft, on the ground that the second operation is much simplified by the freedom from the bleeding occasioned by division of the muscles. Mr. Smith, on the other hand, stretched the palate by drawing upon all the sutures, divided the palato-pharyngeus and levator palati, and then, if the edges of the cleft did not come easily together, made two lateral oblique cuts, one on either side, above the higher suture, separating, to a limited extent, the soft from the margin of the hard palate.

Bonfils, according to Dubrueil, closed an opening left at the upper part of the palate by the partial failure of an operation for staphyloraphy, by taking a flap from the hard palate, according to the Indian method of autoplasty (q. v.).

URANOPLASTY.

Vernieuil attributes the success of modern uranoplastic operations to the use of the method by double flaps, adherent at both ends and brought together laterally (*lambeaux en pont*), and to the retention of the periosteum in the flaps. He ascribes the first use of double flaps to Dieffenbach, and thinks the retention of the periosteum was brought about by Ollier's most valuable experimental and clinical researches upon the properties of this tissue. To Von Langenbeck, by whose name the method is usually

known, he gives only the credit of being the first to adopt Ollier's suggestion, and to make it a rule of practice.

This estimate of the facts does not seem to be entirely correct. It is true that Dieffenbach used double lateral flaps, but a large part of the success of the modern method is due to the greater breadth now given to the flaps. Tillaux has shown that the branches of the posterior palatine artery are given off like the plumes of a feather, and that to avoid division of these branches, and insure the nutrition of the flap, the incision must be made close to the alveolar process. This necessity is as absolute in the case of a small perforation as in that of a larger one. As for the retention of the periosteum, Von Langenbeck was certainly the first to point out its importance as a means of preventing gangrene of the flap. Ollier's investigations turned upon its value in favoring reproduction of the bone.

Fissure of the hard and soft palate endangers an infant's life by interfering with the ingestion of food. The exact measure of this danger has not yet been established by statistics, but it is certainly considerable¹. On the other hand, all recorded operations for cleft palate upon children less than one month old have terminated fatally, and those undertaken during the first five or six months of the child's life, although not so fatal, show but few successes. Billroth and Simon think the operation should be performed about the eighth month, but most surgeons are agreed upon the propriety of postponing it until the third or fourth year. If a child has lived six months without operation, it has certainly learned to overcome the mechanical difficulties in the way of its nourishment, and there is, consequently, no reason to interfere surgically until the second indication arises. That is found in the defective articulation and phonation occasioned by the lesion, and, as children with cleft palate do not begin to speak before the third or fourth year, the operation may be safely postponed until that time.

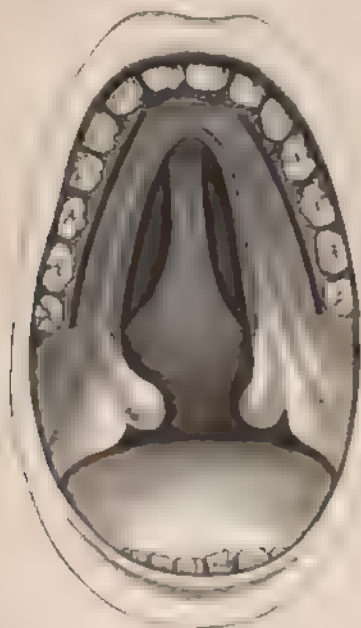
The special instruments required are a speculum oris, or two blunt hooks to be placed at the angles of the mouth and fastened together by a rubber band passing behind the head, pronged forceps with long handles, curved needles of

¹ Langdonnet. *Mém. de la Soc. de Chirurgie* 1877, p. 475.

the pattern selected, a periosteum elevator bent at a right angle on the flat, a small knife similarly bent, and sponges on long handles.

The edges of the perforation or fissure are first freshened by the removal of a strip one or two millimetres thick. An incision is then made on each side close to the gum, extending from the last molar tooth forward as far as may be necessary, and exposing the bone throughout. The elevator

FIG. 202



Incisions in transplasty

is introduced into this incision and the periosteum separated from without inward, care being taken not to injure the palatine arteries at the anterior and posterior palatine foramina.

If the cleft involves the soft palate its sides will be found to round off toward the hamular processes, and the velum

to be tightly adherent to the posterior portion. The flaps cannot be brought together until the attachments of the two halves of the velum at these points are entirely separated, a step which may be accomplished by means of a small, curved, sharp elevator introduced through the lateral incisions, or by the bent knife introduced through the fissure.

The bleeding during this stage of the operation is very free, but, as Ehrmann¹ has remarked, usually ceases as soon as the flaps are completely liberated. If it continues pressure should be made for a few moments with the finger, or ice applied. Trélat carries his incisions further back, stopping from one-fourth to one-half an inch behind the posterior border of the hard palate, and entirely disregarding the posterior palatine artery.

The flaps are brought together in the median line and the sutures applied, beginning at the anterior extremity of the cleft. The sutures should be left in at least four days and then removed, not all at once, but by instalments.

If the fissure is unilateral, the vomer remaining attached on the other side, Von Langenbeck recommends that the lateral incision along the gum should be made only upon the side occupied by the fissure. The flap on the other side should be dissected up from the median line outward.

If the fissure extends through the dental arch and is wide at the point, Rouze² recommends that one of the flaps should be detached in front also and swung in sideways upon the posterior attachment as a centre.

This method of operating has practically superseded all others for closing congenital defects in the hard palate. A great number have been proposed and more or less extensively used, but are now so seldom resorted to that only a few need be briefly mentioned for purposes of reference.

Sir Wm. Fergusson's³ osteoplastic method consisted in cutting through the alveolar margin of the hard palate on each side, fracturing the anterior extremity of the strips of bone covered with their mucos-periosteum and uniting them in the median line. Schouborn⁴ made a flap base down

¹ *Mémoires de l'Académie de Médecine*, vol. xxxi.

² *Journal de l'Académie de Médecine*, Séances du Palais, 1871, p. 108.

³ *Practical Medicine*, April 1, 1851.

⁴ *Langenbeck's Archiv*, 1851, vol. xix, p. 327.

from the upper part of the posterior wall of the pharynx. It comprised all the soft parts in front of the vertebrae; this was turned and brought forward into the cleft. Lanne-longue turned down a flap of muco-periosteum from each side of the septum of the nose and united the free edges to the freshened margins of the gap in the hard palate.

More recently Davies-Colley¹ has fashioned muco-periosteal flaps of nearly equal size from the whole of the under surface of the rudimentary palatine processes of the superior maxilla and palate bones. The pedicle of flap No. 1 occupies the whole length of one side of the cleft. The pedicle of No. 2 corresponds to the posterior border of as much hard palate as exists on that side. No. 1 is turned over into the gap, thus placing its raw surface inferiorly; No. 2 is then slid over this raw surface as far as possible without tension, and sutured. The denuded lateral areas are left to heal by granulation.

Acquired losses of substance in the hard palate, if of any magnitude, are best treated by an "obturator" or vulcanized rubber plate, which a dentist can fit into the roof of the mouth.

EXCISION OF THE TONGUE.

Excision of the tongue, partial or complete, may be rendered necessary by hypertrophy of the organ or by the presence of a tumor. The hemorrhage is controlled by ligation of the vessels as they are divided or by preliminary ligation of one or both lingual arteries. Langenbuch² has devised a method of so placing two temporary ligatures upon the tongue that bleeding is entirely prevented during the removal by the knife of any portion of the anterior half or even two thirds of the member. He enters the point of a well-curved needle carrying a stout ligature a little to the left of the median line of the tongue behind the part which is to be removed, passes it deeply down through the substance of the tongue, and brings it out on the right side through the floor of the mouth so as to include the branches of the lingual artery in its loop. To

¹ British Med. Journ., October 25, 1900 and April 28, 1901.

² Archiv für klinische Chirurgie, vol. xlii, part 1, 1878, p. 72.

prevent slipping, the needle is then passed through the edge of the tongue; another is passed in the same manner on the opposite side, and each tied tightly. The ends may then be used to draw the tongue forward.

It has also been suggested that, when it is necessary to operate very far back upon the tongue, its base can be brought forward by dislocating the lower jaw downward and forward simultaneously on both sides.

The tongue is drawn well forward, the tumor or portion to be removed seized with double-pronged forceps and rapidly excised by a V-shaped incision made with a blunt-pointed bistoury so as to avoid injury to the vessels in the floor of the mouth; all bleeding points are then secured and the sides of the wound brought together with sutures.

If a larger portion, say a lateral half, of the tongue is to be removed, the operation may be done as follows: Two stout ligatures are passed through the tip, one on each side of the median line, to be used to draw the organ forward; the tip then raised, the frenum cut with scissors, and the scissors then pushed along under the tongue and mucous membrane to free them as far back as necessary. Then the tongue is split along the median line, from before backward, completely freed from the underlying parts by tearing with the finger, the mucous membrane of the floor divided with the scissors, and the posterior section made with knife or scissors.

Complete, through the Mouth.

This operation has been extensively employed by Whitehead,¹ and bears his name. He does not practise a preliminary ligation of the lingual arteries, but secures them as they are divided.

The mouth is made as aseptic as possible and the face and neck shaved and cleaned. The lingual artery on each side is ligated; and through these incisions, which may be extended if necessary, any enlarged or suspicious glands, including one or both submaxillaries, are removed. The wounds are then closed and dressed antiseptically.

After this the patient's head is placed in a more or less

¹ *Lancet*, 1881, vol. i. p. 628.

erect position with a slight inclination forward, to allow the blood to escape from the mouth. The jaws are held well apart with a suitable month gag and a ligature passed through the tongue in the median line about an inch from the tip. With this the tongue is drawn out and up, while first the frenum and then the anterior pillar of the fauces are divided by blunt-pointed scissors. With short snips of the scissors all the muscles with the overlying mucous membrane on the under surface of the tongue are cut on a plane with the lower border of the inferior maxilla and as far back as the safety of the epiglottis permits. It may be necessary to draw the lower incisor teeth and thus gain more room for manipulating the scissors. The tongue is then drawn upward by the ligature passed through its substance and the posterior section completed with knife or scissors. The dorsalis linguae vessels can be readily secured in the stump.

Regnoli's Method. Regnoli, of Pisa, published in 1838 the description of a method by which he successfully removed the anterior portion of the tongue. He made a semicircular incision through the skin along the lower border of the jaw, beginning and ending at the angles, and added a second one to it in the median line, extending to the hyoid bone. The tegumentary flaps were dissected back, and the muscles divided at their attachments to the inferior maxilla. The tongue was then drawn down through the large opening thus made, its anterior portion readily excised, and the wound closed. Billroth has revived and modified Regnoli's operation and employed it in several cases. It has the advantage of furnishing free drainage, allowing the wound to be treated antiseptically, and facilitating the removal of implicated lymphatic glands.

Billroth's Method. A semicircular incision is made along the lower border of the inferior maxilla from one angle to the other. The flap, containing the skin, fascia, and platysma, is dissected back and the lingual arteries tied beneath the hyoglossus muscle, as described on page 52.

Enlarged or suspicious glands, including the submaxillary and sublinguals, are dissected out. After transfixing

the tip of the tongue with a ligature to prevent its falling back and closing the opening of the larynx, a knife is thrust up through the floor of the mouth close behind the symphysis and swept backward on both sides as far as the anterior pillars of the fauces. It should divide the mucous membrane and muscles attached to the jaw near enough to the bone to clear all disease and yet leave sufficient tissue to permit the divided muscles to be at least partially sutured in position again.

FIG. 203.



Removal of the tongue. K. Kocher's incision. S. Sedillot's incision.

After the attachments of the geniohyoid, geniohyoglossus, and digastric muscles have been severed, together with the anterior part of the hyoglossus, the tongue is drawn out through this gap and excised. A drain is introduced, the muscles sutured in position, and the wound closed.

Lateral Supra-hyoid Method. Kocher¹ (Fig. 203). This method has for its object the very thorough removal of all

¹ Deutsche Zeitschrift für Chir., 1880, vol. 134.

diseased tissues of the tongue and pharynx and all infected glands in the neck. Preliminary laryngo-tracheotomy is advantageous to facilitate the operation and permit antiseptic treatment of the wound. The mouth is disinfected by washing with a salicylic and borax solution.

The incision is made from the under border of the lower jaw near the symphysis, in the direction of the anterior belly of the digastric, to the hyoid bone, thence backward to the anterior border of the sterno-cleido-mastoid, and then upward along it to or above the angle of the jaw; after division of the platysma and fascia the triangular flap is turned up.

The submaxillary fossa is then emptied by removal of the submaxillary and diseased lymphatic glands, the facial and lingual arteries and veins having been divided between double ligatures.

The larynx and œsophagus are then covered with a sponge forced in behind the tongue, and an incision made into the floor of the mouth by cutting through the mylo-hyoid muscle close to the jaw, and carried along the bone as far as may be necessary.

The tongue is now freely accessible through the wound, and can be drawn out through it and split, and cut off as near its base as is desirable, or it can be entirely removed in the same manner, the opposite lingual artery being readily secured when divided. The side, and even the posterior part of the pharynx, are also accessible.

The tracheotomy tube should be retained, the wound packed with antiseptic gauze, and the patient fed through an œsophageal tube.

Schillot, commenting upon Regnoli's case, expresses the opinion that the excision could have been accomplished quite as readily through the mouth, and, as he also found by experiments upon the cadaver that the tongue cannot be brought far enough forward through such an opening to facilitate excision at or near its base, he suggested and employed division of the inferior maxilla in the median line as a preliminary operation.

Sédillot's Method. (Fig. 203.) One of the median incisor teeth on the lower jaw having been drawn, an incision

is made in the median line from the free border of the lower lip to the hyoid bone, and the jaw sawn through in the line of the incision, or, better, by two oblique lines forming a \gg , the apex directed to one side. The attachments of the genio-hyo-glossus muscles to the bone are next divided, the two halves of the jaw drawn apart, the tongue pulled forward and to one side, and its attachments to the hyoid bone divided on the other side, in doing which the lingual artery is divided and must be tied at once. The tissues on the other side are then divided in a similar manner, and the other lingual artery having been tied the remaining attachments are severed and the tongue removed.

The divided maxilla is fastened together again with silver sutures passed through holes pierced in it with a drill, the sides of the incision in the lip accurately adjusted to each other, and the lower angle of the wound left open for drainage.

The bone has sometimes been divided on the side instead of in the median line.

Von Langenbeck makes an incision from the angle of the mouth vertically down to the thyroid cartilage. Through this the submaxillary and lymphatics are extirpated, the digastric and hyoglossus muscles cut through, the lingual artery tied, and the jaw sawn obliquely in front of the masseter from above downward and backward. After drawing apart the segments the mucous membrane is severed from the inner surface of the posterior one as far back as the anterior pillar of the fauces. Through this gap not only the tongue but also the tonsil and soft palate can be removed if necessary. The operation is concluded like Sédillot's.

Billroth's modification of this consists in dividing the jaw and overlying soft parts on both sides, and turning down the intermediate chin segment.

Crespi and Bastianelli have still further modified Langenbeck's operation as follows: An incision is carried vertically down through the middle of the under lip and chin to the lower border of the jaw, along the latter horizontally to near the angle, and thence vertically down for

about an inch to the anterior border of the sterno-mastoid muscle. The soft parts are separated from the outer surface of the jaw to within an inch of the insertion of the masseter, the facial and lingual arteries ligated, the salivary and lymphatic glands removed, and the jaw divided obliquely from behind forward in front of the second molar tooth. This affords access to the retrobuccal and pharyngeal region, and permits of removal of the tonsil and adjoining parts.

DIVISION OF THE FRÆNUM.

The tip of the tongue is raised upon the handle of a director, in the slit of which the frænum is engaged, and divided with curved scissors close to the director. Only the semi-transparent edge of the constricting band should be cut, and then the rest torn by pressing the tongue up toward the roof of the mouth. If the ranine vessels should chance to be divided the bleeding can be controlled by torsion or ligation or by touching the points with nitrate of silver, or, if necessary, with the actual cautery. J. L. Petit reported a case of suffocation caused by the tongue falling back upon the glottis after division of the frænum, and Guérin mentions another.

RANULA.

The anterior wall of the cyst should be caught up with toothed forceps and excised. A director should be passed at intervals between the sides of the incision to prevent reunion, and the filling up of the sac may be hastened by painting its interior with nitric acid or tincture of iodine. In some cases it is sufficient to pass a thread or wire seton through the cyst.

SALIVARY FISTULA.

Salivary fistula communicating directly with portions of the parotid gland can usually be closed by cauterization and compression, but when the fistula communicates with

Steno's duct the cure is much more difficult. If the distal portion of the duct is still permeable a leaden wire may be passed through it from the mouth into the proximal portion of the duct. The saliva will follow the wire, and if the fistula does not close spontaneously its edges should be pared and brought together with sutures. The orifice of the duct is readily found opposite the second upper molar tooth.

When the distal portion of the duct is obliterated several methods may be employed. One is that of Deguise, and consists in the formation of a new channel in the cheek for the saliva; another is that of Professor Van Buren, and consists in the bodily transfer of the fistulous orifice from the outer to the inner surface of the cheek.

Deguise's Method. Deguise made a puncture through the fistulous opening obliquely backward to the inner surface of the cheek and passed one end of a leaden wire through it; he next made through the same opening a second puncture directed obliquely forward, brought the other end of the wire through it and tied the two ends together. The loop of the wire being thus drawn into the fistula the saliva followed its two branches into the mouth, and the fistula healed at once. Some surgeons use a silk ligature and tie it tightly so as to cut through the tissues included in the loop. Agnew's method of doing this is by the passage of a curved needle around the duct from within the mouth.

*Prof. Van Buren*¹ cured a salivary fistula, the result of a gunshot wound, by passing two fine silver wires through the skin at opposite points on its edge, then isolating the duct and fistulous opening for half an inch by dissection backward from the latter, making an incision through the wound to the inner side of the cheek, drawing the fistulous opening through it, and fastening it there by means of the wires. The gap left on the cheek was then closed with fine silver sutures.

¹ New York Medical Journal, vol. 1 p. 33, and Contributions to Practical Surgery, 1863, p. 205.

The duct was so short, the fistula being an inch behind the anterior margin of the masseter, that it could not be brought quite to the inner surface of the cheek. The wires, however, which were left in place until the fifth week, kept open a track, which became permanent, for the passage of the saliva from the end of the duct to the mouth.

CHAPTER IV.

OPERATIONS PERFORMED UPON THE NECK.

BRONCHOTOMY.

This is a general term covering operations undertaken to open the larynx or cervical portion of the trachea. These operations are: *Laryngotomy*, *tracheotomy*, and *laryngo-tracheotomy*. Laryngotomy is further subdivided into *sub-hyoid pharyngotomy*, or *laryngotomy* (called *supra-laryngeal bronchotomy* by Sedillot, and *indirect laryngotomy* by Planchou), *thyroid laryngotomy* or *thyrotomy*, *crico-thyroid laryngotomy*, and *tracheotomy*, which is further subdivided into high and low, depending upon whether the trachea is opened above or below the isthmus of the thyroid gland. The names indicate the points at which the opening is made into the air-passages.

Sub-hyoid Pharyngotomy or Laryngotomy. This operation, originally performed upon animals by Bichat for the purpose of studying the movements of the vocal cords, was afterward proposed by Vidal to give access to an abscess situated in the glotto-epiglottidean folds, and by Malgaigne to allow the removal of a foreign body lodged in the upper part of the larynx. It is also applicable to the removal of polyps situated at the same point and not accessible through the mouth. Pollin thus removed ten from the anterior surface of the arytenoid cartilages.

The shoulders are raised and the head extended. A trans-

verse incision two inches long, its centre in the median line, is made through the skin immediately below the hyoid bone, and the platysma, sterno-hyoid, and thyro-hyoid muscles, and thyro-hyoid membrane divided. The mucous membrane lying between the epiglottis and the base of the tongue then presents in the incision, is drawn downward with forceps, and opened with the knife or scissors. The epiglottis is then seized with a hook or pronged forceps and drawn out through the wound, freely exposing the larynx to view.

Velpeau made the first incision in the median line, divided the thyro-hyoid membrane transversely, and then plunged the knife backward and downward, making a vertical incision in the base of the epiglottis through which he passed the blades of a pair of forceps and withdrew the foreign body.

*Aplavin*¹ has modified this operation as follows: With the head well extended the trachea is opened and plugged by a tampon canula—a tracheotomy tube surrounded by a rubber bag, which is inflated after its introduction till it fills the lumen of the trachea. The pharynx is incised transversely as above described and the hyoid bone cut through with scissors on each side from one-half to three-quarters of an inch in front of its extremities. If there is fear of wounding the lingual vessels a part of the hyoglossus muscle is cut close above the hyoid bone and the vessels recognized and drawn up. By raising this segment of bone and depressing the thyroid cartilage, pretty free access can be obtained to the parts close around the opening of the larynx.

At the conclusion of the operation the mucous membrane is sutured first; then external to it a silk suture is passed on each side through the skin and upper border of the thyroid cartilage behind and over the hyoid bone about one-half an inch in front of its points of division. After uniting the thyro-hyoid membrane and overlying soft parts the two silk ligatures are knotted externally and thus prevent undue tension on the other sutures.

Thyroid Laryngotomy or Thyrotomy. In this operation the thyroid cartilage is divided vertically in the median line, between the anterior attachments of the vocal cords. It is suitable for the removal of foreign bodies or polyps from the interior of the larynx and for fractures, stenosis, or disease of this organ.

The head is well extended, or allowed to hang from the edge of the table. A preliminary tracheotomy and plugging of the trachea may be necessary.

Steadying the larynx with the thumb and forefinger of his left hand, the surgeon makes an incision along the projecting angle of the thyroid cartilage in the median line, from its upper border to the cricoid cartilage. As soon as the crico-thyroid membrane is exposed, he makes a small opening in it near its upper border and passes one blade of a strong blunt-pointed pair of scissors through it to the upper border of the larynx, keeping exactly in the median line, and thus divides the thyroid cartilage throughout its entire length. Or a grooved director may be passed through the opening made in the crico-thyroid membrane, and the cartilage divided upon it with a curved bistoury. Or, again, the division may be made with the knife, layer by layer, from before backward; but whenever possible the upper border of the larynx should be left uncut to preserve the relation of the vocal cords.

The conoid and thyro-hyoid ligaments and thyro-hyoid membrane must often be separated to a greater or less extent from the upper and lower border of the thyroid cartilage to permit its lateral halves to be retracted sufficiently to expose thoroughly the cavity of the larynx.

At the conclusion of the operation the wound may either be closed immediately with silk or silver-wire sutures, or left open and packed for a couple of days.

Crico-thyroid Laryngotomy. In this operation the opening is made in the crico-thyroid membrane. The French writers, Sédillot, Dubrueil, Chauvel, speak of this method as having been entirely abandoned because the opening cannot be made sufficiently large. Holmes, on the other hand, considers it suitable in all cases in which only the vocal cords or the tissues above them are involved, and says

it is practised in spasm of the glottis from any cause, in erysipelatous affections spreading down the throat, and in cases of foreign body lodged in or above the glottis. If the opening proves to be too small it can be enlarged downward through the cricoid cartilage (laryngo-tracheotomy). The operation may be required in cases of urgency when no tube is at hand. A pair of forceps or scissors, a hair-pin, or pieces of bent wire will suffice to keep the wound open, and the incision can be made with the penknife.

Operation. Dorsal decubitus, shoulders raised upon a cushion or narrow pillow so that the head may fall back and keep the throat tense. The surgeon, standing at the patient's right side, fixes the larynx with his left thumb and middle finger placed on either side, and the index upon its upper border, and makes a cutaneous incision in the median line corresponding to the crico-thyroid membrane. He draws the sterno-thyroid muscles apart, lays bare the membrane, and divides it transversely or vertically; in the latter case the incision should begin a short distance below the inferior border of the thyroid cartilage, so as to avoid a small artery which crosses at that point, and extend to the cricoid cartilage. (For the method of inserting the canula, see *Tracheotomy*.)

Laryngo-tracheotomy. The opening occupies part of the crico-thyroid membrane, the cricoid cartilage, and the first two or three rings of the trachea. The upper border of the isthmus of the thyroid usually corresponds to the second ring of the trachea; it should not be divided. In children under six years it commonly rises to the lower border of the cricoid cartilage.

Dorsal decubitus, with shoulders raised, head thrown back, and neck slightly stretched. The larynx is fixed as for crico-thyroid laryngotomy, and an incision made through the skin exactly in the median line from the middle of the thyroid cartilage to about one inch below the cricoid. The muscles are carefully drawn apart, the isthmus of the thyroid depressed if necessary, after nicking and tearing with blunt hooks the suspensory fascia at its upper border, the trachea steadied and drawn upward with a sharp hook

thrust into the upper part of the crico-thyroid membrane, and the point of the bistoury entered close below the hook and made to cut downward through the cricoid cartilage and one or two of the rings of the trachea. The edges of the incision are then held apart and the canula introduced, or the forceps if the operation has been undertaken with a view to the removal of a foreign body or a polyp.

De Saint Germain's Method. Dorsal decubitus, shoulders raised, neck extended. The surgeons feels for the cricoid and thyroid cartilages, and the depression between them. Then, standing upon the patient's right side, he places his left thumb and middle finger on either side of the larynx, and by pressing them in between it and the vertebral column, pushes the larynx forward, makes tense the skin covering it, and at the same time marks the situation of the lower border of the thyroid cartilage with the nail of his left forefinger.

The knife, a straight, sharp-pointed bistoury, is held like a pen, its back directed upward, and the middle finger so placed upon its side as to limit to half an inch the depth to which the point can penetrate. It is then entered with a quick sharp stab in the median line close against the nail of the left forefinger and made to cut downward with a sawing motion through the cricoid cartilage and one or two tracheal rings, care being taken to make the incision in the skin fully as long as that in the trachea. The wound is held open with a "dilator," and the canula introduced between its branches; the pressure of the latter is usually sufficient to arrest hemorrhage, but ligatures can be easily applied if necessary. In only one case out of ninety-seven did Saint Germain injure the posterior wall of the trachea, and in only three did hemorrhage occur.

Tracheotomy. The trachea may be opened at any point between the cricoid cartilage and the upper border of the sternum, a distance averaging in the adult from two and one half to three inches, in the child under ten years of age from one and one-half to two and one-half inches. Its

course is obliquely backward as well as downward, so that while its upper end is almost subcutaneous it becomes deeply placed before it passes behind the sternum. It is crossed at its upper end by the isthmus of the thyroid gland, the breadth, thickness, and vascularity of which vary within very wide limits, although its upper border usually corresponds to the second ring of the trachea. A communicating branch uniting the two inferior thyroid arteries crosses just below the lower border of the isthmus. The lower portion is covered anteriorly by the thyroid veins, always greatly distended when the respiration is obstructed, and by the thymus gland in children under two years of age, and occasionally in unhealthy older ones.

To the dangers depending upon the normal arrangement of the parts are added those of not infrequent anomalies in the origin and course of the arteries and veins. Thus, the left brachio-cephalic vein may cross the trachea well above the sternum, the left carotid may arise from the innominate, and sometimes a thyroidea ima artery is given off from the transverse portion of the arch of the aorta, and ascends along the anterior surface of the trachea in the median line. Finally, an aneurism of the innominate, or of the arch of the aorta, may rise in front of this portion of the trachea.

Operation. The patient is placed upon his back with shoulders raised and head thrown back. A trustworthy assistant, standing behind the head, holds it firmly in a straight line with the body; others control the patient's limbs if he has not been anesthetized. The surgeon, standing at the patient's right side, recognizes with his finger the hyoid bone and thyroid and cricoid cartilages, and, marking with his left forefinger the upper border of the cricoid cartilage, makes an incision downward from it in the median line from one and one-half to two inches in length, according to the size of the patient. He carries the incision through the skin and fascia, separates the sterno-hyoid and sterno-thyroid muscles with the handle of his knife, and lays bare the isthmus of the thyroid. If any large veins are encountered, they must be carefully drawn aside or divided between two ligatures, but bleeding from smaller ones may be safely disregarded, for, as Trousseau pointed out, it will cease as soon as the trachea is opened, and the

venous congestion relieved by the admission of air to the lungs.

It is well to have one or two assistants hold the sides of the incision apart during the dissection, if they can be depended upon to do so without disturbing the relations of the parts by drawing too forcibly toward one side or the other.

The isthmus of the thyroid is next drawn upward with a blunt hook, and three or four rings of the trachea exposed below it, and divided from below upward. If for any reason it is desirable to make the incision higher up, or if the isthmus is unusually broad, it may be divided between two ligatures, in which case the incision of the trachea should be made from the lower border of the cricoid cartilage downward.

FIG. 204.



FIG. 205.



Bivalve cannula closed

Bivalve cannula with tube in place

The incision in the trachea should always be free enough to admit the cannula readily, and should be made by a quick thrust with a sharp-pointed knife, which must be prevented from penetrating too deeply at first, by holding it close to its point. After the puncture has been thus made, it is enlarged by gentle sawing movements of the knife, or with scissors.

The knife is retained in the trachea as a guide, until the dilator or bivalve cannula (Figs. 204 and 205) has been introduced. The best dilator is the three-bladed one; it is introduced closed, its blades then expanded, and the perma-

nent canula passed in between them. The canula should be curved, double to facilitate cleaning, and provided with an opening on its convexity through which the expired air can pass to the larynx.

Some surgeons steady the trachea by drawing it toward the chin with a tenaculum introduced at the lower edge of the cricoid cartilage. Curdson Buck used for this purpose a rather narrow lance-shaped knife, bent at a right angle on the flat, and also grooved on the back for use as a director.

Galvano- or Thermo-cautery. The danger of hemorrhage, especially in the adult, has led many surgeons to use the galvano- or thermo-cautery. Its hemostatic advantages, however, are offset by a large eschar which it causes, and the possible necrosis of the tracheal cartilages.¹ The cautery should be used only to divide the soft parts, the trachea should be opened with the knife. Saint Germain has also sought to prevent hemorrhage by making the incision with a red-hot bistoury.

LARYNGECTOMY.²

Complete. A preliminary tracheotomy is necessary. A pad is placed under the shoulders and the head thrown well back. The incision is in the median line, and extends from the thyro-hyoid space to the second or third tracheal ring. A transverse incision joins this at the upper end and passes outward parallel to the hyoid bone as far as each sterno-mastoid muscle. The skin, fascia, and platysma are drawn aside and the superior thyroid arteries secured at the posterior margin of the thyro-hyoid muscle beneath the sterno-hyoid close to the upper border of the thyroid cartilage. Next the inferior thyroid arteries are ligated below, beneath the posterior edge of the sterno-thyroid muscles.

By means of a periosteal elevator or blunt pointed scissors entered beneath the fascia in the middle line the crico-thyroid, sterno thyroïd, and thyro-hyoid muscles on each side are detached and retracted with the other soft parts. The

¹ See the discussion in the *Société de Chirurgie* May 21 & June 15, 1877.
² Hahn. *Vollmann's Sammlung*, 1855, No. 260.

thyroid cartilage is drawn first to one side and then to the other, and the inferior constrictor muscle separated. All cutting should be done with the blunt-pointed scissors kept close to the cartilages. The superior laryngeal nerves and the thyro-hyoid membranes and ligaments are divided, the epiglottis drawn out and its extra-laryngeal attachments cut. The larynx is next pulled forward and separated from any remaining connection with the pharynx or œsophagus to a point just below the cricoid cartilage. Great care is necessary to avoid opening the œsophagus. The trachea is secured from slipping down by a temporary suture on each side and is cut across below the cricoid cartilage. The divided end is secured at the surface in the wound with interrupted silk sutures and the mucous membrane sutured to the margins of the skin incision.

When there is doubt about the extent of the laryngeal disease, immediately after the vertical skin incision the thyroid cartilage should be split in the middle line. This is done by steadying the larynx and cutting from before backward with the knife or from below upward with a blunt-pointed scissors entered through the crico-thyroid membrane. If then on inspection it is found that the whole larynx must be sacrificed the operation is proceeded with as already described. It is usually recommended to remove the cricoid cartilage in all cases of total extirpation, as it is of no functional value and its retention interferes with the act of swallowing.

Partial. The vertical skin incision in the median line is employed as in total laryngectomy. At the upper end of the vertical incision a horizontal incision passes out from it parallel to and just below the hyoid bone on the affected side as far as the sterno-mastoid muscle. This involves the skin, fascia, and platysma. The thyroid cartilage is then divided vertically exactly in the median line with the knife or scissors.

After separation of the alæ M. Buttin¹ advises, if the disease is of limited extent, that it be cut away, with a wide margin of healthy tissue, meaning that it be scooped out of

¹ Op. Surg. Malig. Disease.

the concavity of the ala with the surrounding mucous membrane. The ala of the thyroid is then restored to its place. M. Buttin claims that cancer does not infiltrate the cartilage, and therefore it is only necessary to scrape and cauterize the part adjacent to the disease.

If one-half of the thyroid cartilage must be removed, the sterno-thyroid muscle is cut at its upper end and laid back. The thyro-hyoid, sterno-thyroid, and crico-thyroid muscles are carefully detached with the elevator or blunt-pointed scissors. The thyroid and crico-thyroid membranes and superior laryngeal nerve are cut close to the cartilage, and any vessels are secured as they are divided. The superior cornu of the thyroid cartilage is cut through at its base. The whole or part of the epiglottis is left and the aryteno-epiglottic fold of mucous membrane spared as much as possible. The pharyngeal wall must be freed with great care. The inferior cornu is divided, any remaining attachments severed with short snips of the scissors and the ala removed.

The parts are then sutured in their proper positions as nearly as possible after placing over the denuded surface all the mucous membrane obtainable.

PHARYNGOTOMY.

This is an operation required for the removal of foreign bodies or diseases from the pharynx or immediately adjoining parts which are not accessible through the mouth. Langenbeck's (page 361), or the Crespi-Bastianelli methods (page 361), for reaching the base of the tongue are also useful for exposing the tonsil and posterior pharyngeal wall. Aplanin's sub-hyoid pharyngotomy (page 365) gives a somewhat limited view of the parts around the entrance to the larynx.

Gaps left after excision of portions of the walls of the pharynx must be left to granulate; if the epiglottis has been disturbed its attachments must as far as possible be replaced and sutured in their proper position.

*Von Langenbeck's Method.*¹ After a preliminary tracheotomy the head is extended and chin turned to the side opposite to the one in question. The incision extends from the middle of the lower border of the horizontal ramus of the inferior maxilla downward across the greater cornu of the hyoid bone along the posterior border of the thyro-hyoid muscle to the cricoid cartilage or a little further. After division of the superficial fascia, platysma, and omohyoid, the lingual, and superior thyroid arteries and facial vein are cut and secured. Both branches of the superior laryngeal nerve are divided. After freeing the attachments of the digastric and stylo-hyoid from the hyoid bone the pharynx is laid open through the whole length of the wound. The thyroid cartilage can be turned on its long axis so that its posterior surface is visible in the wound and the pharynx is accessible as high as the soft palate.

Another method of the same surgeon's is as follows: A U shaped flap of skin and subcutaneous tissue is made, the base of which is above and corresponds in width to the length of the zygoma. Its sides and bottom follow the anterior border of the masseter muscle, the posterior border of the ramus, and the intervening portion of the lower border of the jaw, respectively. The inferior maxilla is sawn through in front of the insertion of the masseter, and the ramus dislocated by turning it outward and upward.

Butlin² describes an operation by Czerny, which is virtually the same as Von Langenbeck's for excision of the tongue. The incision extends from the angle of the mouth to the extremity of the hyoid bone, and the jaw is sawn through obliquely from above and without downward and inward between the second and third molar teeth.

*Mikulicz's Method.*³ After a preliminary tracheotomy and plugging of the fauces or larynx an incision is made from the tip of the mastoid process to the level of the greater cornu of the hyoid bone. The periosteum and overlying parts are raised from the outer and inner surface of the ascending ramus of the inferior maxilla, special care

¹ *Archiv f. klin. Chir.* 1879, Bd. 34, p. 22.

² *Opérat. Surg. Mém. Univer.*

³ *Deut. med. Wochens.* 1886, No. 2, p. 17.

being taken to avoid injury if possible to the facial nerve, parotid gland, and external carotid artery. The ascending ramus is then divided horizontally just above the angle, and partially or entirely excised after severing the tendon of the temporal muscle.

After drawing aside the body of the jaw, together with the masseter, internal pterygoid, digastric, and stylo-hyoid muscles, the region of the tonsil is exposed. The lateral wall of the pharynx is then incised and access thus obtained to the palate, base of the tongue, and posterior pharyngeal wall as far up as the naso-pharynx. If the digastric muscle and hypoglossal nerve are divided the entrance of the larynx can be reached. The disease is removed with the knife or scissors, the mucous membrane drawn together, and the wound closed and drained.

Cheever's Method. An oblique incision is made from the lobule of the ear downward along the anterior border of the sterno-mastoid muscle to the hyoid bone or below it. A second is carried forward from this along the lower border of the body of the inferior maxilla. The tissues are divided layer by layer, and the vessels including the external jugular secured. Enlarged lymphatic glands are removed as they are encountered. The branches of the facial nerve are recognized and drawn to one side. The hypoglossal nerve lies behind and in the lower end of the incision, and is drawn outward and backward with the great vessels. The glosso-pharyngeal nerve lies anteriorly.

The fascia investing the posterior part of the submaxillary gland is slit up, and the facial artery and vein tied. The digastric and stylo-hyoid muscles are divided, the submaxillary gland drawn forward and the parotid up, and the walls of the pharynx thus exposed.

The tonsil and the surrounding mucous membrane are then removed. Bird¹ dispensed with the incision along the lower border of the jaw, but slit the cheek from the angle of the mouth to the angle of the jaw and removed the tonsil, using one finger in the mouth for a guide.

ŒSOPHAGOTOMY.

The œsophagus begins in front of the sixth cervical vertebra in the median line, or just behind the cricoid cartilage; at first it inclines slightly toward the left, then returns to the median line as it passes behind the sternum, inclines to the right at the arch of the aorta, and again to the left as it approaches the diaphragm. The left recurrent laryngeal nerve lies between its cervical portion and the trachea, the right recurrent nerve lies upon its outer side. It is covered anteriorly by the trachea and left lobe of the thyroid gland, and crossed by the left inferior thyroid artery and vein. The guide to it is the trachea.

Internal Œsophagotomy. Dr. Sands employed an instrument constructed on the principle of the Otis urethrotome. It consisted of a long shank carrying a bulb with a sheathed knife which could be made to project not more than an eighth of an inch from the surface of the enveloping bulb by turning a screw in the handle. Other surgeons have used similar instruments, but on account of the danger of perforating the œsophagus operations performed by the knife from the interior of the organ have been practically abandoned in favor of Abbe's "string saw" method,¹ which is one of combined dilatation and division.

It is used for cicatricial strictures which are undilatable and generally impermeable to any instrument passed from above, but which reason and experience have shown may be passed from below, as in the latter situation the tube is contracted and funnel-shaped, while above it is dilated and pouched.

Gastrostomy is first performed, the opening into the stomach being made large enough to admit two fingers with the exploring instrument to the cardiac orifice of the stomach. Into the latter a bougie carrying a long silk cord is passed and brought out at the mouth; the other end of the cord remains in the abdominal wound. Then the stricture is made tense by engaging in it a conical bougie as large as it will hold, and the string, held well back in the pharynx

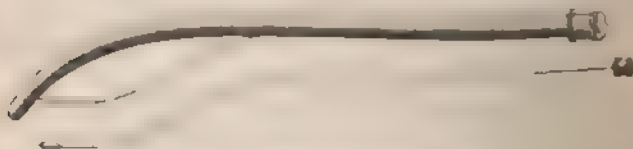
¹ New York Medical Record, February 25, 1883.

and stomach, is drawn tight and sawed up and down a few times. After this bougies are passed up to the largest size or till firm resistance is encountered. In Abbe's first case external œsophagotomy was performed, and after division and dilatation of the stricture as above described a rubber tube was drawn up from the stomach and wedged into the contraction for twenty-four hours, thus maintaining the dilatation.

When there is no further trouble in the passage of bougies from above, the gastrostomy wound is closed, but instruments must subsequently be introduced through the stricture at regular intervals till the danger of recontraction is over.¹

External Œsophagotomy. The operation of external œsophagotomy may be required for the relief of stricture, or the removal of a foreign body. In the former case, it may be performed above or at the level of the stricture for the purpose of dividing or dilating it, or below the stricture so as to allow the introduction of food into the stomach. The left side of the œsophagus is more accessible in the neck than the right, and the incision may be made in the median line or parallel to the inner border of the sterno-cleido-mastoid muscle. As the walls of the œsophagus are flaccid, a guide should be used if it is possible to introduce one. The best one is the instrument known as Vacca Berlinghieri's sound (Fig. 206). It is

FIG. 206.



Vacca Berlinghieri's œsophageal sound

a hollow metallic instrument, curved at one end like a urethral sound, but to a less degree, with a long opening in the concavity or on the left side, extending not quite to

¹ A résumé of this operation with a report of cases and description of the various instruments which may be necessary will be found in the *Annals of Surgery* March, 1886, p. 253. Dr. Woodney.

the end. Within the sound is an elastic staff, the side of which can be made to project through the opening and distend the œsophagus, its point being engaged in the cul-de-sac at the extremity of the sound. In some cases the foreign body can be used as a guide.

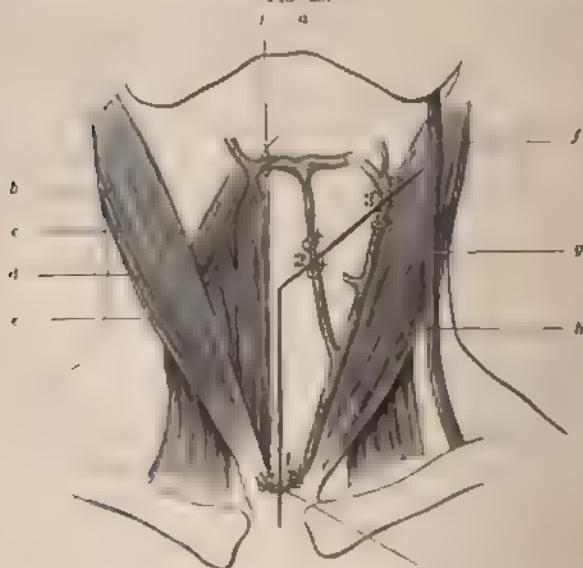
Lateral Incision. Dorsal decubitus, head extended, face turned slightly to the right. The surgeon, standing at the patient's left, makes an incision through the skin, subcutaneous cellular tissue, and the platysma a little on the inner side of the inner border of the sterno-cleido-mastoid from a point one inch above the sternum to the level of the upper border of the thyroid cartilage. If the external or anterior jugular is encountered, it must be drawn aside or divided between two ligatures. The fascia is then divided, the omo-hyoid muscle drawn aside, and then the side of the thyroid gland followed downward. The sterno-cleido-mastoid and the great vessels are drawn outward with a blunt hook, the trachea and thyroid gland to the right, and then the surgeon, working with his fingers or blunt instruments, separates the tissues at the bottom of the wound and exposes the œsophagus, which can be recognized by its flattened appearance and muscular wall. If more room is needed, the sternal head of the sterno-cleido-mastoid must be divided. Vacca's sound is then introduced through the mouth, its elastic staff projected through the lateral opening so as to distend the œsophagus, and recognized by the finger at the bottom of the wound; or an ordinary œsophageal bougie is used. The surgeon, having satisfied himself that the recurrent laryngeal nerve and inferior thyroid artery are out of the way, punctures the œsophagus by picking it up with two hooks or toothed forceps and cutting between them, and enlarges the opening with scissors or a blunt-pointed bistoury.

At the close of the operation the wound in the œsophagus is closed with catgut, that in the overlying parts being left open and packed; the patient is fed by the rectum or with the stomach tube for several days. If a permanent fistula is desired (below a malignant contraction, for instance) the margins of the cutaneous and œsophageal wounds are united with sutures.

THE OPERATIONS ON THE THYROID GLAND.

Anatomy. Normally the isthmus is about half an inch long and covers the second and third tracheal rings, while the lateral lobes extend upward and backward to the lower end of the pharynx, lying on each side of the larynx, and downward, in contact with the upper end of the œsophagus.

FIG. 207

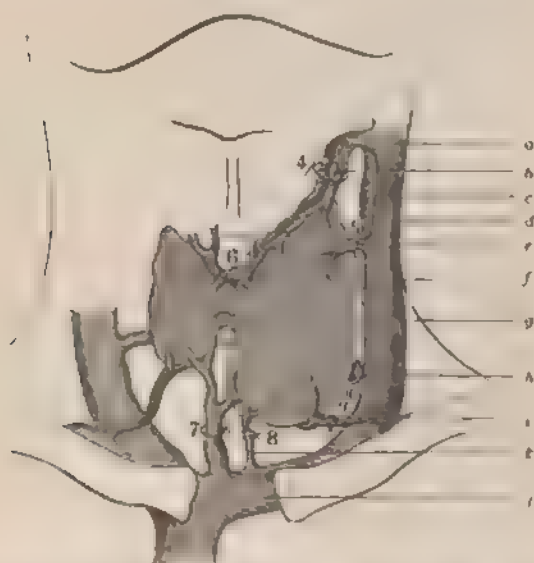


a Clavi. b Sternocleidomastoid c Omohyoid d Sternohyoid e Sternothyroid f Vena jugularis ext. g Vena jugularis obliqua. h Vena jugularis int. i Vena jugularis inf. communicans. k Vena jugularis sup. communicans. 1, 2, 3 Double ligatures applied to the above-mentioned veins in the line of the incision. KOCHER.

The thyroid is enveloped by the fascia of the neck and possesses a capsule enclosing the gland tissue proper. When enlarged the organ is covered with a plexus of veins; the most constant and important of these are represented diagrammatically in Figs. 207 and 208 and need no further ex-

planation. The gland is overlapped by the sterno-mastoid and has resting on its surface the sterno-hyoid, omo-hyoid, and sterno-thyroid muscles in this order from before backward. One or more accessory thyroids may be found above

FIG. 208.



a Sup. thyroid artery b Sup. thyroid vein c Carotid artery d Internal jugular vein e Accessory sup. thyroid vein f Sup. communicating thyroid vein g Inf. communicating thyroid vein h Accessory inferior thyroid vein i Inferior thyroid vein k Thyroidal ima veins l Left innominate vein. The numerals indicate the points where the above-mentioned veins are ligated.

or below the lateral lobes, and it should be noted that the latter may, when enlarged, extend downward behind the sternum. The lateral lobes overlap the great vessels of the neck with their accompanying nerves, and are in contact at their lower posterior portions with the inferior thyroid artery, the recurrent laryngeal nerve, and middle cervical ganglion of the sympathetic. The artery passes horizontally inward from the inner border of the scalenus anticus muscle about half an inch below the carotid tubercle,

then forward on the œsophagus and trachea, and divides into an ascending and descending branch. At its point of bifurcation it is crossed (in front or behind) by the recurrent laryngeal nerve, and at the inner border of the scalenus anticus the middle cervical ganglion lies directly upon it. Great care is necessary in securing the artery not to injure these structures; paralysis of one recurrent nerve produces paralysis of the corresponding vocal cord, of both nerves, severe dyspnoea, which may end fatally if not relieved by tracheotomy; injury to the sympathetic at this point destroys the three cardiac branches which are given off here or just below. The operations which are considered justifiable are removal of a *portion* of the gland, enucleation of the same, and ligation of the afferent arteries, the latter being applicable to rapidly growing, vascular (not fibrous or cystic) goitres in young subjects.

Ligation of the Arteries. On account of the danger of a general atrophy only those vessels in immediate connection with the enlarged part should be secured, the superior and inferior thyroid arteries of one side, for example. Then if this fail the others, starting with the nearest, may be successfully tied. The superior arteries are exposed and ligated as described on page 39, and the inferior preferably by Drobeek's method (p. 40), especially if the gland is much hypertrophied.

Enucleation of a Portion of the Gland. Some cases of sharply defined tumor of the thyroid, such as cystic goitre, need only a longitudinal incision over the most prominent part of the growth with division of the tissues layer by layer, and ligation of the vessels encountered till the gland is reached. The capsule and layer of gland tissue (sometimes no thicker than a sheet of paper) overlying the tumor is then divided and the latter shelled out.

Removal of a Portion of the Thyroid Gland (Kocher). The incision extends vertically in the median line from the sternal notch to the upper limit of the tumor. From this point it runs obliquely toward the angle of the jaw on the side from which the affected half of the gland is to be removed

(Fig. 207). If the entire gland is to be removed, a procedure which must be seldom justifiable, the oblique incision is made on both sides, thus giving the skin-cut the form of a Y. The integument, fascia, and platysma are divided and the flaps turned back. The sterno-hyoid, sterno-thyroid, and omó-hyoid muscles, which may be much thinned and stretched out over the surface of the tumor, will have to be cut. If adherent to its surface they should be lifted and pushed aside with blunt-pointed scissors or a periosteal elevator. A plexus of large thin-walled veins, which tear very easily, will be found lying close over the surface of the enlarged gland, and should be divided separately between double ligatures. The anterior surface of the growth is thus cleared and the lateral aspect approached. The sterno-mastoid muscle is retracted and the common carotid artery and internal jugular vein are carefully freed with a blunt instrument. The superior thyroid artery is secured at the upper extremity of the tumor and, together with the accompanying veins, divided between a double ligature. It is generally recommended to cut the branches of the inferior thyroid artery close to the tumor and secure each as it is divided, as in this way there is less danger of injuring the recurrent laryngeal nerve which is in close relationship with it on both sides. Furthermore, on the left side the main portion of the artery lies in contact with the œsophagus and the thoracic duct, which is at first posterior to the artery, arches over it to reach the left subclavian vein, or the trunk of the inferior thyroid artery may be tied, preferably by Drobeck's method, as described on page 40.

The dissection is continued close to the capsule, which must nowhere be opened; every vessel, as it is encountered, is tied and cut separately after careful inspection, and the lateral surface of the tumor cleared. Its margin is lifted up, starting at one side above and working downward and inward; the trachea and œsophagus are separated with special regard for the recurrent laryngeal nerve which lies in the groove between these structures. Thus the dissection is carried from the side as far as the middle line posteriorly. The gland is then drawn forward and upward. The vessels entering it from below are secured and divided and the gland removed.

*Removal of the Isthmus.*¹ A median longitudinal incision is employed. It extends from the upper to the lower border of the enlarged isthmus and involves the integument and superficial fascia. The anterior jugular vein, if encountered, is secured and cut between a double ligature. The interval between the sterno-hyoid and sterno-thyroid muscles is opened up and the muscles drawn aside. The isthmus is exposed after carefully ligating separately each one of the enlarged veins which may be encountered in front of it. It is then freed on its upper and lower border and posteriorly with a blunt instrument. The capsule itself must not be opened and every vessel should be tied as it is encountered.

An aneurism-needle threaded with a double ligature is then made to perforate the isthmus on each side from behind forward at its junction with the lateral lobes, and at these points it is tied off like an ovarian pedicle and the isthmus cut close to the ligatures and removed.

The parenchymatous injection of tincture of iodine, of iodine and absolute alcohol, or of a mixture of iodoform, ether, and olive oil has been practically abandoned as too dangerous. With every antiseptic precaution a hypodermic needle was plunged into the enlarged gland, and if blood or fluid could be withdrawn it showed that a vessel or cyst had been entered and negatived the injection. When, after reintroduction, the point of the needle was thus demonstrated to occupy only gland tissue, from half a gramme to a gramme of tincture of iodine was slowly injected, the surgeon desisting immediately on the appearance of syncope or dyspnoea.

CHAPTER V.

OPERATIONS UPON THE THORAX.

AMPUTATION OF THE BREAST.

THE patient is placed upon her back, inclined somewhat toward the opposite side, and the arm abducted so as to make the skin and pectoral muscle tense. Two curved in-

¹ Jones. *Lancet*, 1875, vol. i. p. 123.

cisions are made, one on each side of the nipple, enclosing an elliptical strip of skin of greater or less breadth according to circumstances, the long axis of which is directed toward the axilla; that is, upward and backward. The upper and lower skin flaps are then dissected off the anterior surface of the gland, its upper border turned, exposing the pectoral muscle, and the loose cellular tissue between it and the muscle rapidly divided with a few strokes of the knife, beginning at the upper border of the inner angle, while the gland is drawn away from the chest wall, and the removal completed along the lower incision, or at the axillary angle of the wound.

Bleeding during the operation must be controlled by clamps upon the bleeding points, and the vessels secured afterward with ligatures or by torsion. The incision is then prolonged just posterior to the anterior fold of the axilla, up to the arm. The axillary vein is exposed at the outer end of the incision, where it is most superficial and is kept constantly in sight as the dissection progresses. The axillary glands whether perceptibly enlarged or not, together with the surrounding fat and connective tissue, are removed *en masse*.

Halsted¹ advises that the fascia covering the pectoralis major under the breast be *always* dissected off from the surface of the muscle, and in many cases that the latter together with the pectoralis minor be removed entirely.

PARACENTESIS OF THE THORAX.

Each of the lower posterior intercostal arteries enters its corresponding intercostal space near the spinal column, and passes obliquely from below upward across the space to shelter itself in a groove on the inner side of the lower border of the upper rib. It occupies this groove until it reaches the anterior third of the space, when it leaves it to anastomose with the branches of the anterior intercostal artery coming from the internal mammary. At this point, however, it is so small that its division is not of much cou-

¹ *Annals of Surgery*, 1901.

sequence. The only part of its course where its injury is to be feared is in the posterior third of the intercostal space before it has passed behind the lip of the rib. Consequently, if an opening is to be made into the pleural cavity, either with a knife or trocar, a point in the middle third of one of the intercostal spaces should be selected, preferably the seventh, certainly not higher than the sixth, nor lower than the eighth on the right side, the ninth on the left.

After determining the position of the intercostal space, often a matter of considerable difficulty in consequence of the infiltration of the parts, make an incision parallel to it, one or one and one-half inches in length. Divide the tissues layer by layer, until the rib can be distinctly felt with the finger introduced into the wound. Place the end of the finger upon the upper border of the lower rib, and, keeping the knife close to the border, divide the muscles and pleura.

If a trocar or the aspirator is used, it must be thrust in with a sharp push so as certainly to penetrate the pleura, which is often thick and tough. The outer end of the canula is then connected with a Dieulafoy or Potain aspirator by means of a rubber tube and the effusion drawn off. A better method is to make use of the principle of the siphon. After filling the canula and tube, previously rendered aseptic, with sterilized water, the end of the tube is occluded and the canula thrust into the pleural cavity. The tube is then conducted beneath the surface of a 1:60 solution of carbolic acid below the level of the patient's bed, and released, thus siphoning off the liquid in the chest.

PARACENTESIS OF THE PERICARDIUM.

Normally the pericardium is in contact with the chest wall only in the median line under the sternum; but when its sac is distended with liquid the area of contact becomes much larger, especially by extension downward and to the left. The heart is at the same time pressed upward and backward. The limits of the pericardium can be ascertained with great accuracy by percussion and auscultation, and this should always be done before puncturing. At the

point selected for puncture the pulsations of the heart should be imperceptible, or at least very faint, and it should be absolutely flat on percussion. It should also be remembered that the internal mammary artery runs parallel to the side of the sternum, and a finger's breadth from it.

If the knife is used the tissues must be divided layer by layer, and the finger should always be introduced into the wound before the pericardium itself is incised, to make sure that the heart is not in contact with it.

CHAPTER VI.

OPERATIONS UPON THE ABDOMINAL WALL, STOMACH, AND INTESTINES.

PARACENTESIS OF THE ABDOMEN.

IN order to avoid injury to the different viscera, and especially to the internal epigastric artery, which runs from the middle of Poupart's ligament toward the umbilicus, the puncture should be made either in the median line midway between the umbilicus and the symphysis pubis, or midway between the umbilicus and the anterior superior spine of the ilium. The instrument used is a trocar and canula or the needle of an aspirator. The depth to which it shall be allowed to penetrate is regulated by the finger placed upon its side, and it should be plunged in sharply, without a preliminary incision, at the selected point, which should be absolutely flat upon percussion. As there is a possibility of syncope occurring during the operation, in consequence of the withdrawal of pressure, it is prudent first to pass a broad, many-tailed flannel bandage about the abdomen, crossing its ends behind, so that an assistant standing at each side can draw upon them and tighten the bandage as the liquid escapes. It is usually sufficient, however, to have an assistant make steady pressure with one hand on each side of the abdomen. During the operation the patient should be seated or inclined toward one side.

Should hemorrhage ensue, the attempt must first be made to control it by the pressure of the canula or of a larger gum catheter introduced through the puncture. This failing, the entire thickness of the abdominal wall must be pinched up and compressed, or, in extreme cases, the wound must be enlarged and the vessel tied.

When it is necessary to practise paracentesis upon a pregnant woman, Ollivier recommends the selection of the neighborhood of the umbilicus for the puncture; Scarpa preferred the left hypochondrium, Velpeau the left flank.

LAPAROTOMY.

If time permits preparatory treatment with baths and laxatives is continued for several days, and in a female pelvic case the vagina is rendered as aseptic as possible by numerous 1:2000 bichloride douches. An aperient is given the evening before and an enema in the morning of the operation; the patient passes water or is catheterized immediately before being placed on the table. The preparation of the skin surface, the surgeon, the attendants, instruments, and accessories has been already given. Sterilized sponges, round and flat, and a few on clamps or handles, and pads of gauze should be at hand, and two sterilized basins of warm boiled water, one to contain the clean sponges, and the other, which will need frequent changing, to rinse the soiled sponges.

All parts of the patient, except the abdominal surface, all the tables for instruments, sponges and dressings, and everything not previously sterilized, which may be touched by any person or thing concerned in the wound, are covered with sterilized towels, dry or wet in a 1:1000 bichloride of mercury solution. The numbers of clamps, sponges, and pads are written down immediately before the operation and verified at the close.

The incision may be made in almost any part of the abdominal wall, but is most often median and should divide the tissues layer by layer. The linea alba is indistinct below the umbilicus, and if the incision is median one or other rectus sheath will generally be opened. It will then be

found convenient to immediately unite by a catgut suture the anterior and posterior layers of the opened sheath, and the linea alba can thus be more quickly reformed at the close of the operation. The properitoneal fat is recognized and all bleeding stopped. The peritoneum is then nicked and the opening enlarged with blunt-pointed scissors to the length of the abdominal wound, which must be made large enough to permit easy recognition of everything as it is encountered.

The position of the bladder must be remembered. The field of operation is then fenced in like a well with sterilized gauze pads or flat sponges, and the viscera outside of the spot in question entirely hidden in the rest of the unopened abdominal cavity.

Pelvic operations are much facilitated by the Trendelenburg position—the hips elevated above the shoulders, thus causing the viscera to gravitate out of the way. Each vessel is secured separately, if possible, before division; there must be no cutting in the dark and no ligation of large masses of tissue *en masse*. In general catgut is preferable to silk for almost all pedicles or vessels.

At the close of an aseptic laparotomy the perfectly dry and clean wound is inspected for a few moments to be sure that there is no more bleeding; the clamps, sponges, and pads are removed and counted, and the viscera are then allowed to resume their normal positions. A flat sponge or pad is placed over the viscera in the abdominal wound to protect them and to absorb such blood as may flow from the needle punctures, and over this the wound is closed by various methods.

Silk, silver wire, or silkworm-gut can be passed through the whole thickness of the abdominal wall and peritoneum, from half an inch to an inch from the margin of the wound, and about the same distance apart; the amount of tension necessary in tying them will vary with the thickness of the abdominal wall, its laxity, or distention. Before the last one or two are tied the protecting sponge is withdrawn, or the peritoneum may be first sutured over the sponge by the continuous or interrupted catgut suture and the sponge withdrawn before it is entirely closed, then sutures of silk, silver wire, or silkworm-gut are passed as before, but only

through the parts in front of the peritoneum, or after closing the peritoneum and removing the sponge the overlying parts can be sutured with catgut, layer by layer. Schede¹ recommends buried sutures of silver wire for all the layers except the peritoneum and skin. In a continuously aseptic wound the sutures should not be removed for at least seven days, and then with every antiseptic precaution, especially if they include the peritoneum.

The sutured wound may be covered with a strip of sterilized rubber tissue. Iodoform gauze is next applied, and over this layers of plain, sterilized, or bichloride gauze.

This is held in place with a couple of transverse strips of adhesive plaster and covered with a layer of sterilized absorbent gauze, and the dressing completed by a broad abdominal binder or a broad roller bandage applied circularly around the body and each thigh in the form of a spica to prevent slipping.

The sponges contaminated in the course of a laparotomy, where any form of sepsis or noxious element is present, should be kept apart from the others as far as possible, and only used in the contaminated area, which latter must be kept separated by sterilized sponges or pads, with the utmost care, from the rest of the abdominal cavity. The towels in the neighborhood of the wound are changed or covered with clean ones as fast as they become soiled, and the wall of pads or sponges surrounding the operation area must be replaced by fresh ones when they become saturated with the noxious materials, and without disturbing the position of the protected viscera.

The wound at the finish is made as clean and dry as possible. Wherever peritoneum has been divided or stripped up it should be replaced and secured with fine catgut sutures. There may remain a large denuded area liable to infection or studded with fine bleeding points, as, for instance, after dissection of an adherent tumor. This can be conveniently treated with a large square of iodoform or sterilized gauze, the centre of which is tucked down into contact with this area, and the edges brought out of the abdominal wound. Other strips of sterilized gauze are

¹ *Centralblatt für Chirurgie*, 1885.

packed into this as into a bag. If pus has been present one or more sterilized drainage tubes of rubber or glass with lateral perforations must be run down from the surface to the bottom of the infected region. Sometimes a strip of gauze is packed inside of the tubes to aid the escape of fluid on the principle of capillarity. And this strip is frequently changed with every antiseptic precaution.

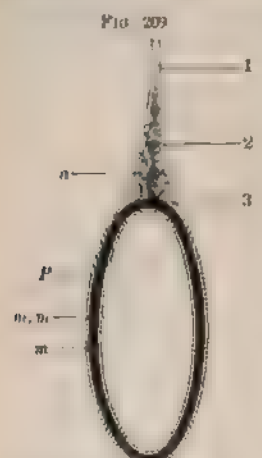
In female pelvic cases it may be desirable to pass a tube through a counter-opening in the vault of the vagina. Hence the necessity of the preliminary cleansing of the vagina in every case where there is even a possibility of pelvic complications. The vagina is afterward packed with sterilized or iodoform gauze, the vulva covered with an antiseptic dressing, and the patient catheterized for several days subsequently. After inserting the tubes, and with as little displacement of the protected viscera as possible, the sponges or pads are removed and counted and their places supplied by a light packing of strips of iodoform or simple sterilized gauze, the ends of which protrude through the incision. Before packing the wound it may be advisable to flush out the infected region with warm boiled water or sterilized salt solution, and sometimes a large part of or the whole peritoneal cavity is thus treated and counter-openings for drainage, with packing, are made.

At the close of the operation the peritoneum is first sutured over a sponge or pad down to the point of exit of the tubes and packing, and the sponge then removed. The overlying parts are drawn together to a corresponding extent with silk, silkworm-gut, or silver wire passed through everything in front of the peritoneum, and a dressing which covered the ends of any tubes is then applied, as in an aseptic case.

OPERATIONS ON THE INTESTINES.

Anatomy. (Fig. 209.) The parts of the intestines which have a mesentery are completely covered by peritoneum except along a narrow interval where the laminae of the mesentery diverge to encircle the bowel (Fig. 209, 2). Thus the outer wall of the gut, along the line where the mesentery

meets it, is formed by a strip of the muscular coat about five-sixteenths of an inch wide (Fig. 209, 3), and this is apt to be



Section of small intestine and mesentery

- 1 Mesentery
 - 2 Triangular space between diverging layers of the mesentery.
 - 3 Its base resting on *m*, the muscular coat of the gut.
- P* Peritoneum.
m, m Mucous membrane

the weak point in a row of sutures involving this portion of the circumference of the bowel. The arteries in the mesentery form freely anastomosing loops from which, close to the intestine, arise straight vessels with little or no intercommunication, and having a circular and fairly well-defined distribution, so that, while a portion of the mesentery at a distance from the intestine may be destroyed with comparative impunity, an injury to the smallest part in immediate proximity to the gut involves a probability of sloughing of a corresponding extent of intestine.

An anatomical knowledge of the mesentery is of value in a search for the upper or lower end of the small intestine. The parietal attachment of the mesentery extends from the left side of the second lumbar vertebra down-

ward to the right iliac fossa, and, if the finger trace the left layer of the mesentery of a loop of intestine back toward the spine, it passes off toward the left side of the abdomen, and the right layer will lead to the right side of the abdomen. This will show which end is the upper or lower in any particular loop. Also the upper end of the small intestine has a greater diameter, is thicker walled (valvule conniventes), and more vascular than the lower end. The coats of the intestine from without inward are: (1) the peritoneal, (2) the longitudinal, (3) circular muscular, (4) the submucosa, a tough fibrous membrane, (5) the muscularis mucosa, and (6) the mucosa, the latter making up about two-thirds of the thickness of the wall.

Unless the suture includes a shred of the submucosa it

is very apt to tear out. This coat is recognizable by the increased resistance which it offers to the passage of the needle after the peritoneal and muscular layers have been traversed.¹ The colon and sigmoid flexure are recognizable by their corrugations, their more or less fixed positions, the appendices epiploicæ, which are most numerous in the transverse colon, and by the longitudinal bands of muscular fibres. The anterior band is the largest and most prominent, and lies in front of the cæcum, colon, and sigmoid flexure. In the transverse colon it corresponds to the attachment of the great omentum, and in the ascending colon and cæcum it is the unfailing guide to the appendix vermiformis, from the attachment of which to the cæcum the anterior, inner, and posterior longitudinal bands all start. The appendix lies about opposite a point indicated on the abdomen by the centre of the line passing from the right anterior superior spine of the ilium to the umbilicus. It may or may not have a mesentery and commonly lies behind the lower end of the ileum, and often in close relation with the iliac vessels and ureter, and is not infrequently found in the pelvis.

To be successful the closure of an intestinal wound must be water-tight, and no stitch may perforate all the coats; there must be no subsequent giving way of any part of the wound, either from slipping of a suture or ulceration or sloughing at the site of its insertion, and the lumen of the bowel must not be unduly narrowed. A round sewing needle and black silk are generally used.

The *continuous suture* is applied like the ordinary continuous suture already described, and is carried a short distance beyond the extremities of a longitudinal wound. The needle penetrates the peritoneal and muscular coats, of the intestine, catching up a few fibres of the sub-mucosa, but nowhere entering the mucosa. The stitches are placed at intervals of about a quarter of an inch close to the margins of the wound, which are turned in to bring the peritoneal surfaces in apposition.

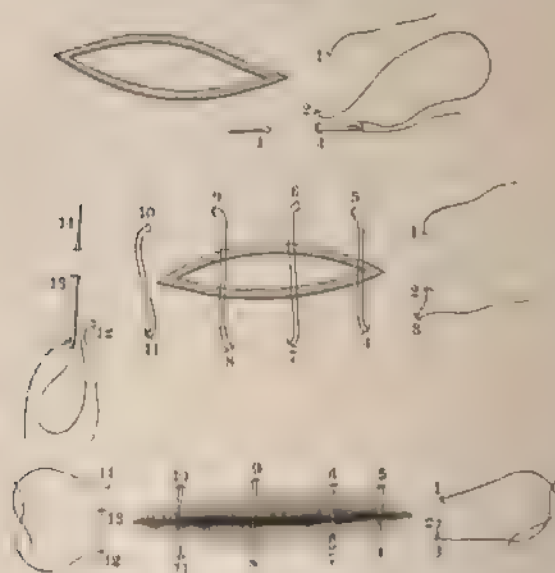
The *right-angled continuous suture* (Fig. 210) only differs from this last in having the buried portions parallel to

¹ Habsted. American Journal Medical Sciences, 1887, p. 426.

the line of the wound and the exposed portions at right angles to it.

The continuous suture can be rapidly applied, and is useful for reinforcing weak points in an interrupted suture

FIG. 210



Right angled continuous intestinal suture. GREG SMITH

line, but it is inapplicable for closing a complete transverse division of the bowel. All parts of the continuous suture may not be drawn equally tight, and the contraction of the gut tends to loosen it and allow the wound to gape.

The interrupted suture of *Lambert* is the most approved and generally used intestinal suture. The needle penetrates a fold of the peritoneal, muscular, and a few shreds of the submucous coat of the gut on opposite sides of the wound, the margins of which are inverted and the peritoneum brought together. The sutures should be placed about an eighth of an inch from the margin of the wound and about the same distance apart, and each should grasp

a fold of the intestine about one-tenth or one-twelfth of an inch wide. None must touch the mucosa.

FIG. 211.

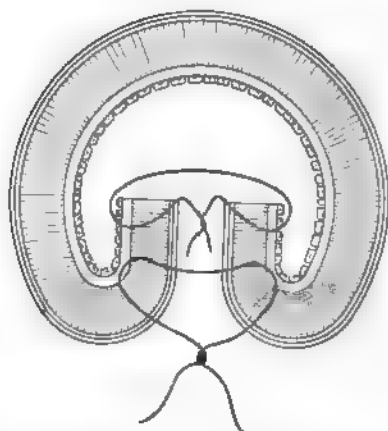
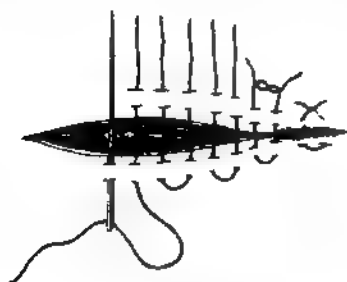


Diagram representing the methods of inserting the Czerny-Lembert sutures. The Lembert suture is below, the Czerny at the cut edge.

Czerny's method consisted of an interrupted line of sutures passing through *all* coats of the intestine and tied inside.

FIG. 212.



Halsted quilt suture for the intestines.

A second row of Lembert sutures is then added to bring the peritoneal surfaces on each side of the wound in con-

tact over the first row of sutures. Czerny's suture is now generally passed through all coats *except* the outer one.

*Holsted's quilt suture*¹ will bear a considerable strain. It is a modification of Lambert's method. The needle penetrates the superficial coats of the gut twice on each side of the wound and is then knotted.

CIRCULAR ENTERORRAPHY.

This is the usual term for designating an end-to-end suture of the intestine from which a segment has been removed.

Operation. The loop of intestine is carefully drawn out of the abdomen and surrounded by warm pads or sponges while the opening into the peritoneal cavity is protected by a gauze or sponge packing. The feces are squeezed out of the loop, and about an inch above and below the limits of the segment of gut to be removed the intestine is constricted tightly enough to close its lumen, either by the fingers of an assistant or by any one of the specially designed clamps. A convenient method is to tie lightly around the bowel at these points a strip of iodoform gauze, which is passed through a small hole made in the mesentery by a blunt instrument at a little distance from the gut. After thoroughly protecting the exposed peritoneal surface, at the spot selected on the lower side of the disease, the intestine is divided squarely across and its interior immediately irrigated with warm boiled water. With a clean pair of scissors, the mesentery of the diseased part is cut as close to the gut as possible up to the intended upper point of the intestinal division.

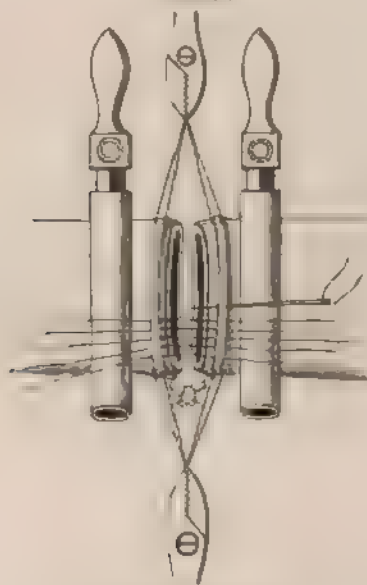
If there is much distention, the iodoform-gauze band above should not be tied till after the freed portion of intestine has been conducted off to one side and its contents allowed to escape, aided by kneading the abdomen. While the gut is being divided the lumen above should be occluded by the pressure of an assistant's fingers; the in-

¹ American Journal Medical Sciences, October, 1887

testine is then constricted about an inch above the upper line of division as already described, and cut squarely across, leaving no protrusion beyond the mesenteric attachment, and the interior below the constricting gauze band immediately irrigated as before.

The divided mesentery should not be removed in the form of a triangle with its base corresponding to the excised gut. Bleeding is checked by separate ligation with fine

FIG. 213.



Circular enterorrhaphy

catgut of each vessel. Meanwhile every portion of peritoneum is scrupulously protected from infectious matter, and before the next step instruments which have touched infectious matter or the interior of the intestine are discarded and the hands carefully washed.

The ends of the gut are then brought into apposition and the mucous membrane united evenly all around by a continuous catgut or silk suture. The mesenteric border of the

gut is drawn together by a Lembert silk suture and then the opposite free border. By gentle traction on the ends of these sutures (Fig. 213) the gut is flattened out and on the line thus indicated the necessary number of Lembert sutures are added, but not tied till the last is in place. The peritoneal surfaces must be very carefully brought into contact at the mesenteric attachment of the bowel to avoid leakage into the areolar tissue between the diverging layers of the mesentery; but weak points must not be so reinforced by continuous or interrupted sutures that the lumen of the intestine becomes unduly narrowed. The fold of detached mesentery is drawn together at its cut edge with catgut, and if long enough it is sometimes advised to suture its peritoneal surface over the line of intestinal union as far as it will reach without tension.

Senn sutures the great omentum over the outer row of Lembert sutures and has thus covered a circular enterorrhaphy with a detached omental graft an inch wide and long enough to encircle the bowel.¹ The parts are again irrigated with warm boiled water, the intestinal clamps or gauze bands are removed together with the protective sponge packing, and after returning the gut to the abdomen the parietal wound is closed in the usual way.

INTESTINAL ANASTOMOSIS.

This is the formation of a lateral communication between the lumina of two different portions of the gut. Owing to the contraction in the calibre of the intestine which follows circular enterorrhaphy, this operation of anastomosis is frequently adopted in its place, though it was originally introduced as a palliative means of relieving an irremovable obstruction of the bowel, by uniting the parts above and below the obstruction.

Operation. Above and below the obstruction healthy portions of the gut are selected which can be brought into apposition without tension, along several inches of surface.

¹ Trans. Int. Med. Cong. 5th session, Washington, 1887, vol. 1, p. 442.

The rest of the peritoneal cavity is walled off with sponges, and if possible the selected loops of intestine are drawn out of the abdomen and surrounded by warm cloths. About one-quarter of an inch to the under side of the centre of the convex free border as the intestine lies exposed, the apposing loops are united for about five inches by a continuous silk suture through the peritoneal coats alone. In front of this, nearer to the free border, is placed a row of Lembert sutures for the same distance. About an inch above and below this suture line, on each loop, an iodoform-gauze band is passed through the mesentery, where it is free from vessels, at a little distance from the intestine, and tied around the gut just tightly enough to prevent the entrance of fecal matter. Each loop is then opened along its convex free border for nearly the same distance (about four inches) parallel to and immediately in front of the second row of sutures already in place. The openings should terminate opposite each other about half an inch short of the end of the suture line. The interior of each isolated loop is immediately irrigated clean with warm boiled water, while the exposed peritoneal surface is protected as far as possible.

Soiled towels or protecting sponges are then replaced by clean ones, anything which has touched the interior of the intestine or its contents is discarded and the hands carefully washed. After this the extruded mucous membrane of the opposite intestinal loops is united by a continuous catgut or silk suture. The exposed parts are again irrigated and the protectives and instruments changed.

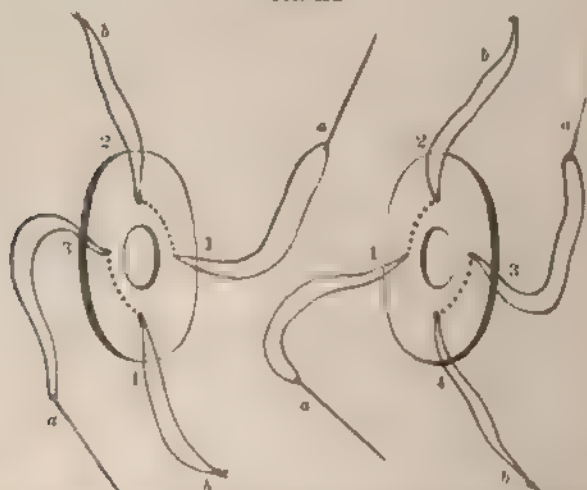
A row of Lembert silk sutures is then placed close to and in front of the already united parts as they lie in view, starting and terminating at the ends of the row of posterior Lembert sutures. This can be strengthened by a continuation of the first posterior continuous silk suture through the peritoneal coat. The four gauze constricting bands are then removed from the intestine, the protective sponges taken out of the abdomen, the bowel returned, and the parietal wound closed in the usual way.

In cases of enterectomy the segment of gut to be removed is excised as described in circular enterorrhaphy. The open ends of the intestine are then turned in to bring

peritoneal surfaces into contact, and closed by a continuous silk suture carried back and forth once or twice and in no spot entering the mucosa. The constricting gauze bands are removed from the intestine and the anastomosis proceeded with.

Senn¹ reinvented and greatly improved the forgotten method of uniting different portions of the gut laterally by means of perforated absorbable plates which bring into contact broad areas of peritoneum around a central opening.

FIG. 214.



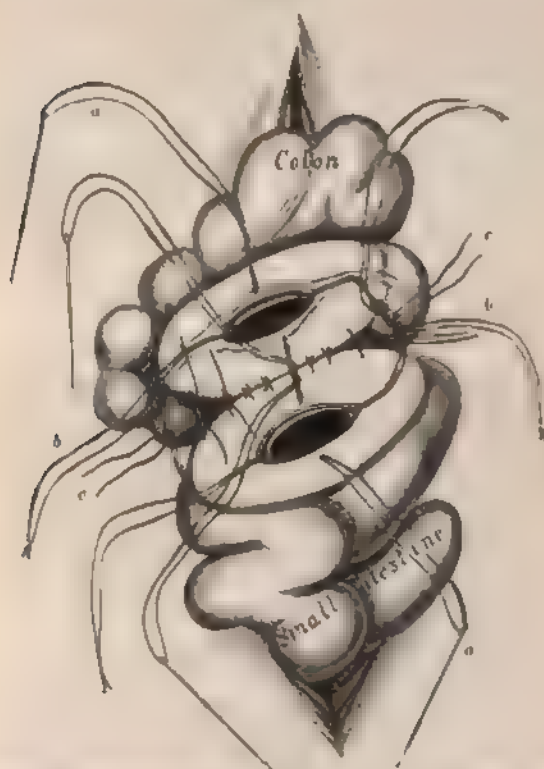
Senn's plates. *a, a*, lateral or external suture. *1, b*, end or apposition suture. Thread passed through 2 is brought out through 1, and that through 4 out through 3. (TILVER.)

Two contiguous loops of intestine are opened to the same extent longitudinally, on the side opposite the attachment of the mesentery, and sufficiently to admit the plates edge-wise. After introduction the plates are rotated enough to make their perforations correspond to the openings made in the intestine. About a quarter of an inch from the margins of the openings on each side, the wall of the intestine

¹ Trans. Int. Med. Cong., 25th session, Washington 1887, vol. 1, p. 433.

is perforated by the two lateral sutures which are armed with needles. The other two sutures are tied across the extremities of the openings without perforating the intestinal wall.

FIG. 215.



Intestinal anastomosis, with Senn's plates. *a, a*, lateral or fixation sutures, *b, b*, end or apposition sutures, *c, c*, posterior sutures. (HARR.)

The sutures serve the double purpose of holding the parts in apposition and keeping the openings patent.

After the parts are brought together union is further secured by a continuous or interrupted suture through the peri-

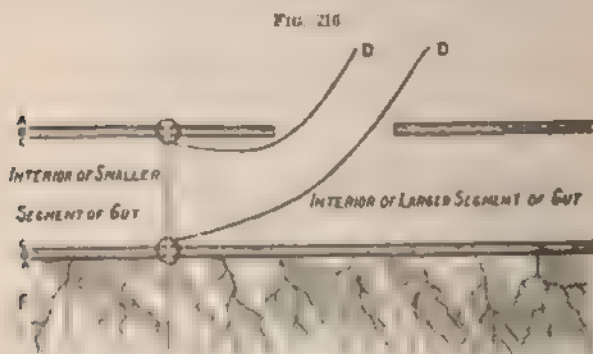
toncal coat around the margins of the plates. The plates, which Senn made of decalcified bone, are supposed to become absorbed or disintegrated between the third and tenth days.

This method has been largely abandoned in this country on account of the later contraction of the fistula.

The Murphy "button" has lately attained great popularity as a means of uniting different portions of the intestine, although its value for this purpose has been contested by many surgeons. A description of the device and its application will be found in the paragraphs on cholecystenterostomy. Quite recently a satisfactory substitute has been found in a piece of raw potato perforated and fashioned into similar shape.

Various methods have been devised for uniting portions of gut of unequal diameter, but they have now been generally superseded by closing the transversely divided ends and performing lateral anastomosis.

Ileo-sigmoidostomy. Cases of irremovable obstruction in the colon have been successfully treated by an anastomosis



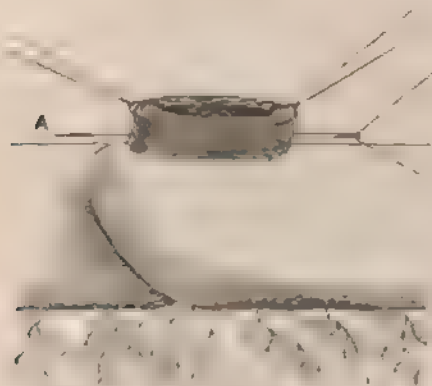
Manns's method; first two sutures brought out through the incision in the lower segment

between the lower end of the ileum and the sigmoid flexure after the ileum has been divided and separated from the

colon at the ileo-caecal valve. The abdominal incision is made in the median line below the umbilicus.

Union of Divided Intestine by Intussusception (Maunsell).¹ The disease is excised by transverse division of the gut as described in circular enterorrhaphy. The cut ends of the intestine are united by one suture through the entire wall at the point of the mesenteric attachment and by another at the point directly opposite. The portion of intestine which lies on the lower or rectal side of the line of division, starting about an inch from this line, is opened longitudinally on its convex free border for about two inches. Through this incision the long ends of the two sutures are passed and the gut invaginated and its partially united cut ends drawn

FIG. 217.



Maunsell's method. protruding ends ready for suture.

out through the opening. (Figs. 216 and 217.) Sutures of fine silk are then passed through both sides of the exposed invaginated gut at the same time close to its cut edge, hooked up from the centre, cut apart and tied. The intestine is then withdrawn from the opening and the longitudinal slit closed by Lembert sutures.

¹ Amer. Journ. Med. Sci., 1892, vol. 103, p. 24A.

ENTEROTOMY.

Instead of excision of a portion of the gut with immediate restoration of its continuity by circular enterorrhaphy or lateral anastomosis, circumstances such as an uncertain amount of gangrene, the bad condition of the patient, etc., may require that the bowel be simply freed from its constriction and the damaged part left outside the abdomen till the slough separates. It is fastened to the margins of the abdominal wound by a couple of sutures through the peritoneal and muscular coats, and protected by a dry antiseptic dressing. In course of time it is treated by the method described for the closure of an artificial anus. Other cases may need to be treated as described for enterotomy or colotomy, with immediate opening of the gut close to or at the seat of disease.

RIGHT INGUINAL ENTEROTOMY (NÉLATON'S OPERATION).

As long ago as 1819, it was proposed to establish an artificial anus in the ileum in case the intestinal obstruction could not be found or removed by laparotomy; but Nélaton was the first (1840) to substitute this for the other operation, giving up the search after the obstruction entirely. His theory was that many obstructions would relieve themselves in time, if a temporary outlet should be furnished to the accumulation above; in some cases, on the other hand, where the obstruction is permanent, an artificial anus in the ileum meets the "vital indication" perfectly—for example, when the obstruction is in the lower portion of the small intestine; while in others, again, where the occlusion occurs below the ileo-caecal valve, and the relief afforded would, consequently, be imperfect, the obstruction is usually due to malignant disease, which in itself would soon destroy life, and against which neither laparotomy nor any other operation would avail.

It is also essential to the proper nourishment of the patient that the greater part of the small intestine should remain serviceable; that is, that the opening should be made in the

lower part of the ileum. Of course, this cannot be accomplished when the obstruction is situated high up, but, in other cases, Nélaton found that the intestinal loops nearest the obstruction always occupied the right iliac fossa, and he, therefore, cut through the abdominal wall just above the outer half of Poupart's ligament on the right side, and opened the first loop that presented in the incision. The portion of the intestine below an obstruction is always empty and shrunken, and does not come into contact with the anterior abdominal wall, so that there is no danger of making the opening in it by mistake. It occasionally happens when the obstruction is situated in the colon that the distended cæcum fortunately presents in the incision, and the artificial anus is established below the ileo-cæcal valve.

Operation. Make an incision parallel to and about an inch above Poupart's ligament, beginning at the anterior superior spine of the ilium and ending opposite the internal abdominal ring.

Divide the tissues layer by layer, pick up and nick the peritoneum and open it for about one and a half inches. The first distended intestinal loop which presents is drawn out till its free border is on a level with the skin, and retained by two silk or silkworm-gut sutures, which, at the same time, draw together the extremities of the abdominal wound. Each suture passes through all the parietal tissues and the peritoneal and muscular coats of the intestine. The skin and bowel are closely united all around by interrupted sutures, none of which must enter the lumen of the gut.

The suture line is covered by a strand of iodoform gauze pasted down with flexible collodion, and the centre of the protruding intestinal wall opened in its long axis for about half an inch.

The parietal peritoneum can be drawn out and stitched to the skin before the bowel is sutured in place, thus bringing into contact a larger surface of parietal and visceral peritoneum.

COLOSTOMY.

Left Inguinal Colostomy. Make an incision between two and three inches long, according to the thickness of the

abdominal wall, parallel to and about an inch above Poupart's ligament, with its centre at the level of the anterior superior spine of the ilium, or a little lower. The tissues are divided layer by layer, the peritoneum opened, and the skin and parietal peritoneum united by a few sutures, not including the muscles. The sigmoid flexure, which is recognized by its anterior longitudinal band, its convoluted surface, or appendices epiploicæ, is drawn into the opening and retained by a couple of silk or silkworm-gut sutures passed about two inches apart through both lips of the wound at its extremities and the longitudinal band of the colon. The gut is then closely united to the margins of the wound by fine silk sutures passing through the already joined skin and peritoneum and the outer coats of the intestine. No suture must penetrate to its interior. The amount of the circumference of the gut to lie external to the sutures is about half an inch when the operation is for the temporary relief of obstruction. For a permanent artificial anus two-thirds of the circumference of the bowel should lie anterior to the suture line. The centre of the exposed intestinal wall is then opened longitudinally with a knife or thermocautery for about half an inch and drainage tubes inserted.

Before opening the bowel the suture line can be covered with a strip of iodoform gauze pasted over with flexible collodion. If there is no hurry the opening can be deferred for five or six days till adhesions have shut off the general peritoneal cavity.

Some surgeons prefer not to unite the skin and parietal peritoneum, but to suture the outer coats of the intestine to the skin alone. The gut adhering to all parts between the skin and parietal peritoneum is thought less liable to retract than if adherent only to the intervening parietal peritoneum with its movable subserous areolar tissue.

Maydl¹ hangs the intestine on a sterilized rod passed through the mesentery close to the bowel and laid on the skin transversely to the wound. The apposing walls of this loop are united by a few interrupted sutures through the peritoneal coats and the rest of the walls left to adhere to the abdominal wound; but if immediate opening is in-

¹ *Centralb. f. Chir.*, 1888, No. 24.

tended, the sutures are passed through the skin and peritoneum around the margins of the incision, and through the serous and muscular coats of the gut, completely separating the peritoneal cavity. The exposed wall of the intestine is opened transversely for one-third of its circumference, and drainage tubes placed within it. Two or three weeks later the bowel is entirely divided on this line and the cut edges sutured to the skin for a permanent artificial anus.

If the operation is merely temporary the intestine is opened longitudinally, and when adhesions have formed the rod is withdrawn, and the bowel retracts and the fistula sometimes closes spontaneously.

Right inguinal colotomy only differs from the last operation in that the abdominal incision is placed on the right side and the cæcum is opened instead of the sigmoid flexure.

Median colotomy, by fixing the ascending or descending colon in the median line between the umbilicus and pubes, has nothing to recommend it over the inguinal method.

Lumbar Colotomy. This operation was first suggested by Callisen,¹ in 1797, as a substitute for Littre's or inguinal colotomy with a view to avoiding the dangers incidental to an incision through the peritoneum. He proposed to open the descending colon in the posterior third of its periphery, where it is not covered by peritoneum. So far as known, Amussat was the first to perform the operation in 1839, and although he opened the ascending colon, and by a transverse instead of a vertical incision, the operation was essentially the same as that proposed by Callisen. All that portion of the descending colon which lies above the crest of the ilium is usually uncovered by peritoneum on its posterior aspect, and although the actual breadth of the uncovered portion varies with the degree of distention of the bowel, it usually amounts to one-third of the entire circumference, and is bounded on each side by

¹ Erskine Mason. Six Cases of Lumbar Colotomy, Amer. Journ. of Med. Sciences, Oct. 1873.

one of the three longitudinal bundles of unstriped muscle characteristic of the colon. In position it corresponds nearly to the outer border of the quadratus lumborum, and very exactly to a vertical line drawn a full half inch behind the centre of a transverse one, uniting the anterior and posterior superior spines of the ilium (Mason). On the right side (ascending colon) the uncovered portion is more often smaller, and the existence of an actual mesocolon, although rare, is yet more frequent than upon the left side.

Callisen proposed a vertical incision a little external to the outer border of the erector spine; Amussat made a transverse one midway between the last rib and the crest of the ilium, while Baudens and Bryant used an oblique one passing downward and outward at an angle of 45° . The latter is to be preferred, because, while giving sufficient room, it inflicts less injury upon the vessels and nerves of the parts, the general direction of which is the same as that of the incision.

The operation is performed as follows: The patient is etherized, and placed in a position midway between the prone and right lateral, a hard cushion being placed transversely under the right loin to keep the spine straight or slightly curved toward the left. Mason¹ says the operation has been performed with the patient seated and leaning forward over the back of another chair, local anesthesia being obtained by means of the ether spray. The anterior and posterior superior spines of the left ilium are then recognized, and a vertical line drawn upward from a point one-half to three-quarters of an inch behind the centre of a transverse line drawn from one to the other. This vertical line should be marked with iodine or nitrate of silver, in order to serve as a guide during the operation.

If the occlusion of the intestine has not been complete, and there is reason to suppose that the colon will be found empty, it may now be distended by injecting air or water through the rectum. Mason prefers air, and gives good reasons for the preference.

A transverse or an oblique incision four or five inches

¹ *Loc. cit.*

long is then made, its centre lying in the vertical line above mentioned midway between the last rib and the ilium. The underlying tissues are recognized and divided layer by layer, until the fascia transversalis and quadratus lumborum are reached. The former is next carefully divided, and, if the adipose tissue covering the colon does not then appear in the wound, the latter should be enlarged on the inner side by dividing the outer fibres of the quadratus. The intestine must always be sought for in the angle of the wound nearest the spine, and whenever it is desired to increase its exposed area this must be done in the same direction. Bleeding should be arrested as it occurs, certainly before the intestine is opened.

The colon can usually be recognized by its distention and greenish hue, and possibly by one of its longitudinal bands. Additional light may be thrown upon the correctness of the recognition by noticing whether the supposed colon corresponds exactly to the vertical line marked upon the skin, and whether or not it moves up and down with the acts of inspiration and expiration, for while the small intestine has this motion the lumbar colon has it not.

Two stout ligatures are next passed by means of curved needles through the presenting portion of intestine and used to draw it up into the wound, and fasten it to the skin at the sides of the incision. The wound is then filled with sponges or gauze, and the bowel opened by a longitudinal or crucial incision. As soon as the discharge has ceased, the sponges or gauze are withdrawn, the parts cleaned, the extremities of the tegumentary wound closed with silver sutures, and the edges of the opening in the intestine made fast to the skin with a few sutures of fine silk.

CLOSURE OF AN ARTIFICIAL ANUS OR FECAL FISTULA.

If the opening in the gut is large, the remaining part of the intestinal wall is pressed forward into it and forms a sort of valve or spur, which prevents more or less completely the descending current of feces from entering the lower segment of the bowel.

If this spur were absent the fistula might close sponta-

neously, and to accomplish its removal Dupuytren's enterotome was formerly introduced through the opening and clamped upon the spur, which was thus cut through by four or five days of continued pressure.

FIG. 218.



Dupuytren's enterotome.

Immediately before undertaking any operation the lumen of the gut above and below the fistula is plugged by a sponge tied to a string which serves to withdraw the sponge when all is ready to close the intestinal opening. The interior of the gut is then irrigated clean and the skin surrounding the fistula thoroughly scrubbed and washed with bichloride solution.

In most cases the fistulous tract between the intestine and skin is lined with mucous membrane, and if the spur is slight or absent, an attempt to close the fistula should first be made by separating the mucous membrane at its junction with the skin, and after removing the sponge plugs, inverting it, and uniting the freshened surfaces with fine catgut. Over this the pared edges of the abdominal opening are sutured with fine silk, aided, if necessary at the sides, by liberating incisions through the skin and fascia.

If this fails or a more elaborate operation seems necessary, an incision two or three inches long is carried across the fistula in any suitable direction, and layer by layer down to the peritoneum. This is opened at one extremity of the incision and a finger inserted into the abdomen to determine the limit of the adhesions; and as soon as possible

the peritoneal cavity is walled off by sponges packed in around the open intestine, which has been previously plugged above and below as already described. Cutting on the finger as a guide, the gut is separated from its parietal attachment around the fistula, and if possible drawn out of the abdomen and constricted above and below the plugs by gauze bands passed through the mesentery.

The sponge plugs are withdrawn, the interior of the gut irrigated, and, if the opening is small, its edges are freshened and inverted, and the peritoneal coat drawn together over it with Lembert sutures. The constricting bands are removed and the gut returned to the abdomen, which is closed tight in the usual way. If the opening is extensive, the damaged segment of the gut is excised and circular enterorrhaphy performed, or better still, after excision, lateral anastomosis.

The fistulous tract is then dissected out of the abdominal wall and the wound closed tight.

The Operation for the Removal of the Vermiform Appendix. In a case of appendicitis operated on in the period of quiescence, an incision three or four inches long is made at the outer border of the right rectus muscle, with its centre about on the line joining the umbilicus and the anterior superior spine of the right ilium. The lower extremity of the incision should not reach the deep epigastric artery, the course of which is indicated by a line drawn from the femoral ring to the umbilicus.

The tissues are divided layer by layer, all bleeding stopped, and the peritoneum pinched up and opened the whole length of the incision. Adhesions are separated by the finger-nail or blunt-pointed scissors, and if necessary divided by a double ligature. The anterior longitudinal band of the colon is traced to its origin at the root of the appendix. After walling off the surrounding peritoneum with a sponge packing, the appendix is isolated and a double ligature of stout catgut passed by an aneurism needle through its mesentery close to the root of the appendix. The needle is withdrawn, the loop of the ligature cut, and on one side the mesentery, which usually contains a single artery, is tied off, and on the other side the ap-

pendix is ligated as close to the cecum as possible. The mesentery and appendix are then excised close to the distal side of the ligatures. The cecal stump of the appendix is held isolated and in view till thoroughly cauterized with the Paquelin or pure carbolic acid, but in using the latter care must be taken to prevent its spreading to the neighboring surface of the cecum.

The sponge protectives are then removed, the parts allowed to assume their normal position, and one end of a strand of iodoform gauze is placed in contact with the cauterized stump and the other end brought out of the abdominal wound.

The peritoneum and overlying parts are closed tight in the usual way except where the gauze drain emerges. Here a suture of silk is passed through the entire thickness of the abdominal wall, including the peritoneum, and left untied till the drain is removed forty-eight hours later. This must be done with every antiseptic precaution, and only done if no inflammatory symptoms exist. The dressings then applied are left undisturbed about ten days.

*Dr. McBurney*¹ has given us a method which, while more difficult of execution, obviates the risk of hernia: An incision, oblique downward and inward, is made about an inch and a half to the inner side of the anterior superior spine of the ilium. The aponeurosis of the external oblique is split in the direction of its fibres, the sheath of the internal oblique divided transversely, and its fibres and those of the transversalis carefully separated without cutting from the ilium to the rectus. The fascia and peritoneum are divided, the sides of the opening held apart with broad retractors, and the appendix removed as above described.

Operation during the Period of Inflammation. If a distinct tumefaction is perceptible, with a probability of the presence of pus, the incision is made about four inches long parallel to the outer border of the right rectus over the most prominent part of the tumor, or, if there is no tumefaction, over the most tender spot, and the appendix

¹ *Annals of Surgery* 1891.

removed as already described. If the peritoneum is reached without a previous escape of pus it is opened at an angle of the incision, preferably the upper, and a finger inserted to determine the position of the mass and the limit of the adhesions. Through this exploratory opening a sponge packing is inserted as soon as possible, and the inflamed area walled off from the rest of the abdominal cavity.

The peritoneal opening is then enlarged and the dissection carried into the densest part of the tumefaction. Fresh adhesions are best separated by tearing with the finger-nail, but the possibility of lacerating the bowel must not be forgotten, and, if necessary, the blunt-pointed scissors and double catgut ligature are used for the strongest adhesions, especially those involving omentum. The moment pus appears the manipulations are suspended, while it is encouraged to flow out or else sponged rapidly away without disturbing the relations of the surrounding parts.

The opening in the abscess cavity is cautiously enlarged without getting beyond the adhesions which protect the rest of the peritoneal cavity. If such an accident does occur a clean sponge is immediately packed into the rent and the dissection continued until the appendix is found. It should always be removed to prevent subsequent attacks, and it is always possible to find it by following the anterior longitudinal band of the caecum. It is excised and the stump cauterized in the manner already described.

An abscess cavity in the pelvis may sometimes need to be drained by a tube passed through a counter-opening in the rectum and a cavity in the loin by a tube passed through the back just above the iliac crest.

After every trace of pus has been sponged or washed away one or more tubes should extend from the abdominal wound into every recess of the suppurating region and each surrounded with an iodoform-gauze packing. The sponge protectives are then removed and their places supplied by strips of iodoform gauze, the upper and lower angles of the wound are sutured in the usual way, and a strip of iodoform gauze placed over the intestines beneath them. The ends of all the strips of gauze are brought out at the centre of the wound and counted.

After the first twelve to twenty-four hours the dressings

will probably be saturated with the blood-stained serous discharge and need changing, which then and afterward must be done with every antiseptic precaution. The gauze directly beneath the suture line can probably be removed in twenty-four to forty-eight hours, but it will require a vigorous pull.

STOMACH.

Anatomy. The cardiac orifice lies about one inch to the left of the sternum beneath the seventh left costal cartilage. The pyloric orifice in the empty stomach lies in the median line or close to the right of it and two or three inches below the end of the gladiolus, and is in relation with the neck of the gall-bladder, the portal vein, the gastro-duodenalis, and right gastro-epiploica arteries, the pancreas, and the splenic vein. The lesser curvature is connected with the transverse fissure of the liver by the lesser omentum, which contains from left to right the gastric, pyloric, and hepatic arteries, the portal vein, and common bile duct. The great omentum passes downward from the greater curvature, on which lie the right and left gastro-epiploica arteries, across the colon, to which the anterior layer is generally adherent, the posterior always. The transverse mesocolon is near the posterior surface of the stomach. The left lobe of the liver descends in front of the stomach a variable distance, generally not below the ninth left costal cartilage. When the stomach is distended, it is in contact with the anterior abdominal wall over quite a large area below the left lobe of the liver; when it is empty, this area of contact becomes very small, and lies between the left lobe of the liver and a transverse line drawn at the level of the anterior end of the ninth rib. The guide to this line, as Tillaux has shown, is the anterior end of the tenth rib, which can be readily felt projecting beyond the border of the cartilages of the false ribs, and can be made to yield a sort of friction sound by rubbing it against the ninth. Sédillot claimed that when the stomach was empty, it was nowhere in contact with the anterior abdominal wall, being separated from it by the liver and transverse colon, and recommended that it should be approached by a crucial incision through the left rectus muscle two or three inches below the xiphoid appen-

dix of the sternum. He passed his finger along the border of the left lobe of the liver to the diaphragm, encountered the stomach there, seized it with pronged forceps introduced along the finger, and drew it up to the incision while pressing the colon downward. Although, as stated, more recent investigations have shown that the normal stomach when empty is still in contact with the anterior abdominal wall, these directions for finding the stomach may be useful in cases where it has been drawn back and bound down to the posterior wall by inflammatory adhesions or neoplasms.

GASTROSTOMY.

It consists in the establishment of a fistula through the walls of the stomach and abdomen.

Operation. An incision one and a half or two inches long is made parallel to and a finger-breadth from the free border of the left costal cartilage, ending below opposite

FIG. 710



Anatomical relations of the stomach with reference to gastrostomy.

the end of the tenth rib. The tissues are divided layer by layer, the peritoneum pinched up and opened. When the stricture is close the stomach and intestines are usually empty and the abdomen deeply sunken by atmospheric pressure. In such cases, when each successive layer is divided it rises from the underlying mass, and when the peritoneum is opened the air rushes in and the abdominal wall rises away from the stomach and becomes level with the sternum and ribs. The stomach is recognized just below the left lobe of the liver by its white color, smooth surface, and the arrangement of its arteries. If it does not

present in the wound the transverse colon and omentum are pressed down, the fingers passed up under the left lobe of the liver and to the left close to the diaphragm and vertebral column, and the lesser curvature sought for. When found a fold of the stomach is picked up by the fingers and a spot fixed upon which avoids too much traction and is suitable for a fistula. The method now in favor in gastrostomy is to stitch the parietal peritoneum to the skin all around the incision, and then to fasten the unopened stomach in the wound by several sutures which

FIG. 220.

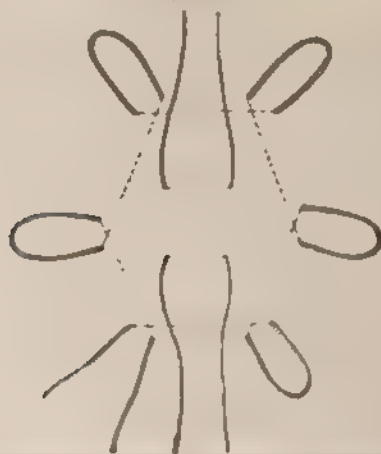


Diagram to show a method of fastening the stomach in a wound of the abdominal parietes. (GREEN SMITH)

traverse its muscular coat but do not enter its cavity, and whose deeper ends then transfix the abdominal wall. This gives a broad surface of contact between the peritoneum of the stomach and that of the abdominal wall, and favors their prompt union. The protruding portion of the stomach may also be transfixed with two long pins which rest upon the skin and prevent strain on the sutures. The opening of the stomach is delayed as long as possible, from one to eight days. If necessary, food can be introduced by puncturing with an aspirating needle.

Another method, after stitching together the parietal peritoneum and skin, is to pass two retention sutures of silver wire through about half an inch of the stomach wall, and about the same distance apart. A continuous silk suture is next passed through the wall of the viscus in a circle about two inches in diameter and brought out and reinserted at intervals of a quarter of an inch, leaving numerous free loops on its surface. (Fig. 220.) No suture must enter the interior of the stomach. Each loop, as made, is passed through the abdominal wall at the margin of the incision and threaded on a rubber tube, around which the wire retention sutures are also passed to assist in holding the stomach. (Fig. 221.)

FIG. 221



Completion of operation represented in Fig. 220.

Witzel¹ divides the skin parallel to the ribs and a finger's breadth distant, then the rectus muscle longitudinally, and the transversalis horizontally. Next the anterior wall of the stomach is drawn into the abdominal wound sufficiently to permit of its being folded lengthwise and sutured over a rubber tube, which at one extremity enters the viscus and at the other is brought out of the opening in the skin. The stomach is then fastened in the wound in the ordinary way by a row of sutures around the folds enclosing the tube,

¹ *Centralbl. f. Chir.*, 1881, p. 601.

and over the latter the skin is united, leaving only a small hole for the exit of the tube. This is intended to make the fistula communicate less directly with the surface of the body, and thus insure better retention of the gastric contents. It is important that the tube should fill and even distend the orifice by which it enters the stomach.



Fig. 222.
Plug of two hollow rubber disks for closing a gastrotomy wound.

The leakage from a straight fistula of this organ can, however, be controlled to a certain extent by a mechanical device consisting of two hollow rubber disks closely joined at their centres by a hollow rubber cylinder communicating with each. The lower disk is passed through the fistula into the stomach, and both disks are then distended with air or water and thus made to block the opening.

In cases where the stomach need not be opened for some days it is sufficient, after uniting the skin and parietal peritoneum, to pass a couple of barelip pins through its outer coats, enclosing a portion of the stomach wall about three-quarters of an inch square. The pins are simply laid upon the skin transversely to the abdominal wound, and the opening made in the centre of the square they enclose after adhesions have formed.

A crucial abdominal incision below the ensiform process was used by Sédillot. Others have employed a vertical incision in the linea alba, in the substance of the outer part of the left rectus, or in the left linea semilunaris.

Hahn opened and fixed the stomach in the eighth intercostal space after first entering the abdomen by an incision parallel with the lowest rib.¹

GASTROTOMY.

This is the operation in which the surgeon opens the stomach and then closes it at the conclusion of the operation.

¹ *Centralb. f. Chir.*, 1890, p. 120.

Operation. If it is performed for the removal of a foreign body which can be felt through the anterior abdominal wall, the incision, at least two inches long, is made over the tumefaction and in the direction which inflicts the least damage on the intervening tissues. Otherwise the incision is made in the median line just below the ensiform process or parallel to the left costal cartilages, as in gastrotomy. The tissues are divided layer by layer, the peritoneum opened, and one finger introduced to locate the foreign body.

After protecting the surrounding peritoneal surface by gauze pads or sponges, the part of the stomach wall to be opened is carefully drawn into the abdominal wound and held there by a couple of temporary retention sutures passed through the peritoneal and muscular coats on each side of the intended opening, which is then made parallel to the course of the bloodvessels, that is, transversely to the long axis of the stomach. The foreign body is removed gently, with due regard for its sharp points, or the ulceration or sloughing which may exist, and if necessary the stomach is washed out. There must be as little sponging or irritation of its interior as possible.

The incision in the stomach is closed by a continuous silk suture of the mucous membrane, then by a row of Lembert sutures, which are reinforced by a continuous silk suture through the peritoneal coat. After the region of the wound has been made dry and clean, the temporary retention sutures are withdrawn, the protecting sponges are removed from the abdominal cavity and the parietal wound closed and dressed as described for an aseptic laparotomy.

Greig Smith does not suture the mucous membrane of the stomach, but closes the wound by a row of Lembert sutures reinforced by a continuous or interrupted suture of the peritoneal coat. The continuous suture prevents gaping of the wound during expansion of the stomach.

By gastrotomy Bull¹ and Richardson successfully removed foreign bodies impacted in the oesophagus near the cardiac orifice of the stomach. Richardson demonstrated that the lower three inches of the oesophagus are thus

¹ New York Medical Journal, October 29, 1887.

accessible by an incision parallel to the left costal cartilages, through which he introduced his whole hand into the stomach and extracted a set of false teeth from the lower end of the gullet.¹

Gastrotomy for Benign Stenosis of the Pyloric or Cardiac Orifices. (Sometimes called Loretta's operation.) Before the operation the stomach is washed out repeatedly with an alkaline solution. The pylorus is reached by an incision four or five inches long, usually in the linea alba between the xiphoid appendix and the umbilicus; or else approximately parallel to and about an inch from the right costal cartilages, starting an inch below and an inch and a half to the left of the xiphoid appendix and terminating near the level of the cartilage of the ninth rib. The tissues are divided layer by layer, and the peritoneum opened. The surrounding peritoneal surface is protected and held out of the way in the usual manner, while the pylorus is sought for, and such adhesions as may exist are divided between double catgut ligatures. The anterior wall of the stomach is drawn into the abdominal wound, and after again carefully protecting the surrounding peritoneal surface is incised transversely for from one to three inches between its two curvatures near the pylorus, but outside of the inflammatory zone adjoining it. Guided by two fingers grasping the pylorus externally, the forefinger of the right hand is passed through the stomach into the pyloric orifice. This may require considerable force, or the orifice may have become so contracted that preliminary dilatation with some small instrument is necessary.

McBurney used a small bivalve anal speculum. Dilatation is continued till it is felt that any further stretching would threaten a rupture of the viscus. The wound in the stomach is then sutured as described in gastrotomy for a foreign body, and, after cleansing and drying the field of operation and removing the protective pads or sponges, the parietal wound is closed as usual.

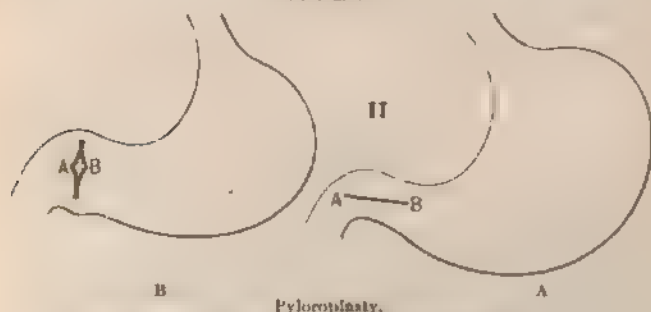
To reach the cardiac orifice, the abdominal incision is made obliquely from a point just below the ensiform pro-

¹ *Lancet*, October 8, 1852.

cess parallel to and about one inch from the left costal cartilages. The anterior wall of the stomach is opened by a longitudinal incision made between the two curvatures and as near the cardiac end as possible.

Instead of performing gastrotomy and divulsion of the pylorus, the stricture can be relieved by longitudinal division followed by transverse reunion. (Fig. 223.) The

FIG. 223.



A The incision, A, B, along the contracted pylorus.

B. Closure of this wound transversely. The point A united to B.

median or right oblique abdominal incision is employed, any adhesions about the pylorus are separated, and after carefully walling off the surrounding peritoneum with sponges an incision opening the lumen of the viscera about an inch and a half long is carried across the pyloric ring, through the neighboring anterior wall of the stomach and first part of the duodenum. The opposite extremities of this incision are then united to each other to form the centre of an apparently transverse wound, Fig. 223, which is closed by the Czerny-Lembert suture. The protecting sponges are removed from the cleaned and dried peritoneal cavity, and the parietal incision closed tight in the usual way.

After relieving the pyloric stenosis, the dilatation of the stomach has been lessened by taking a "tuck" in its anterior wall, a longitudinal fold of which is pushed into the lumen of the viscus, and the opposite external margins of the inverted part united by Lembert sutures.

GASTROTOMY.

This is the operation for closing a wound or opening in the stomach.

Operation. If it is undertaken to close a gastric fistula, the interior of the stomach, the fistulous tract, and surrounding skin are made as clean as possible. A sponge tied to a string is pushed through the fistula and held by an assistant against its interior orifice. An incision is then made not less than two inches long in a vertical or any convenient direction across the fistula and through the abdominal wall, layer by layer, until the peritoneum is reached. This is opened at one extremity of the wound and a finger inserted to determine the limit of the adhesions. On this finger as a director, the peritoneal incision is enlarged around the fistula, which is then surrounded by sponges packed into the abdominal cavity. The liberated stomach is drawn into the abdominal wound, and the margins of the opening in the stomach freshened and closed as described in gastrotomy, after withdrawing the sponge from the interior of the stomach.

The fistulous tract is excised from the abdominal wall, and, after the operation area has been thoroughly cleansed and dried and the protecting sponges removed from the abdomen, the wound is closed in the usual way with or without a gauze packing.

If the operation is undertaken for a perforating wound or ulcer of the stomach, immediately after opening the peritoneal cavity by an ample incision, either median, just below the ensiform process, or parallel to the left costal cartilages, all extravasated material must be sponged away or irrigated out of the peritoneal cavity with boiled water, and the opening in the stomach closed as described in gastrotomy. The operation area is walled around by sponges or pads and a sponge is then passed into the lesser peritoneal sac through a small opening made in the great omentum, between the stomach and transverse colon. If the lesser sac is found infected, or there is even a suspicion of an opening on the posterior surface of the stomach, this

opening must be sought for and closed. If it cannot be reached and sutured through the great omentum (between the stomach and transverse colon), rather than leave it unclosed, Greig Smith advises an incision in the anterior wall of the stomach, and through this suturing the opening in the posterior surface from within. After everything has been made as clean as possible, and all sponges removed from the abdominal cavity, tubes surrounded by a plentiful gauze packing should extend into all the infected regions in the greater and lesser peritoneal sacs and connect them with the skin surface.

The parietal wound is then partially closed and dressed antiseptically.

PYLORECTOMY.

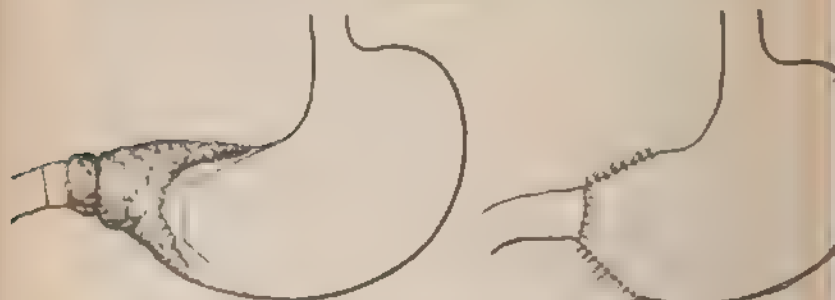
The stomach should be repeatedly washed previously and should be empty at the time of operation. The abdominal incision is made in the linea alba between the ensiform process and umbilicus, or over the most prominent part of the tumor, and more or less transversely, from just to the left of the median line in the direction of the free border of the right costal cartilages and not less than an inch from them. Other forms of incision that have been employed are vertical at the outer border of the right rectus, transverse over the tumor, or crucial. At first the incision is only made large enough for exploration. If then the operation is deemed feasible, it is enlarged till it is from three to five inches long.

Sponges are packed into the abdomen around the tumor, which is drawn as much as possible into the abdominal wound. The great and small omenta are cut close to the greater and lesser curvatures of the stomach, after first securing the vessels between double ligatures, till the point toward the left is reached where the stomach wall is to be divided. Great care must be taken not to wound the portal vein, hepatic artery, or common bile duct which lie behind the pylorus, and no damage must be done to the transverse mesocolon. If the disease involves this structure the operation should be abandoned.

Fresh sponges are now packed around the liberated

pyloric end of the stomach, and the growth, with a margin of healthy tissue, is excised with scissors. All vessels are secured as they are divided, the lumen of the duodenum is immediately plugged by a sponge, and after removing all extravasated matter and renewing the sponge packing around the field of operation, the large opening in the stomach is narrowed on the side of the lesser curvature by Czerny-Lembert sutures till the opening which remains next the greater curvature approximates the size of the duodenum. If circumstances require the implantation of the duodenum

FIG. 224



Pylorotomy. Showing method of narrowing the opening in the stomach.

near the lesser curvature, the opening in the stomach is narrowed below or on both sides in the same way (Fig. 224), the posterior walls of the stomach and duodenum at their respective points of division are then approximated and the margins of the wounds behind are inverted to bring the posterior peritoneal surfaces in contact.

The redundant mucous membrane is raised at its cut edge and sutures of fine silk are passed beneath it from the inside, at intervals of an eighth of an inch, through the muscular and peritoneal coats of the stomach and duodenum. When knotted the sutures lie beneath the mucous membrane, which can be closed over them by a continuous or interrupted suture (Fig. 225), only about the posterior half of the stomach and duodenum can be united in this way.

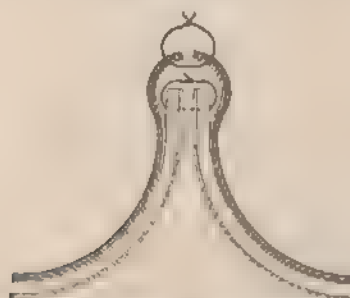
The sponge is then withdrawn from the duodenum and the remainder of the wound is closed by the Czerny-

Lambert suture. After testing the suture line by filling the stomach with water, the operation area is made clean and dry, the protective sponge packing is removed, and the abdominal wound is closed in the usual way.

Senn's omental graft to surround the suture line in the viscera might be useful.

In extensive resections of the pylorus, Billroth and others have closed the resulting wounds in the stomach and

FIG. 225



Wolfer's method of uniting the wound in the posterior portion of the stomach after pylorotomy. The shaded line represents the mucosa.

duodenum by Lambert sutures and then restored the continuity of the alimentary canal by performing a gastroenterostomy.

On account of the high mortality of pylorotomy for malignant disease, this operation is now rarely done; in general it may be stated that when the tumor can be felt through the anterior abdominal wall, it is scarcely justifiable to attempt its removal.

GASTROENTEROSTOMY.

The preliminary washing of the stomach and the abdominal incision are the same as for pylorotomy, but the abdomen is more commonly opened in the median line between the ensiform process and the umbilicus. The first loop of intestine which presents is grasped and traced up-

ward to the duodenum. It should be noted that this part of the gut is thicker, of greater diameter, and more vascular than that nearer the colon. Czerny advises that the origin of the jejunum be sought for at once by drawing up the stomach, great omentum, and transverse colon, and following back the transverse mesocolon to the spine; immediately to the left of this lies the end of the duodenum. A portion is then selected as near to the latter as will permit easy coaptation with the stomach, the great omentum is pushed to the left and the intestine drawn to the right

FIG. 226.



Gastroenterostomy; diagram to show the method of union to secure similarity in direction of the peristalsis of the stomach and intestine.

and upward over the colon. The anterior wall of the stomach near the greater curvature and the selected portion of intestine are drawn as far as possible into the abdominal wound, and the loop of intestine should be so twisted or placed that at the conclusion of the operation the direction of its peristaltic wave shall not be opposite to that of the stomach. (Fig. 226.)

The rest of the abdominal contents are walled off by a protective sponge-packing, and the selected loop of intestine, squeezed empty by the fingers, is prevented from filling by a rubber or gauze band passed through the mesentery and constricting each extremity of the selected loop.

A continuous silk suture through the peritoneal and muscular coats is then made to unite the anterior surface of the stomach near its greater curvature to the posterior surface of the intestine a little to the mesenteric side of its free border, for about four inches.

In addition, a row of Lambert sutures may be placed anterior to the continuous suture, although this is not absolutely necessary. After the rest of the abdominal contents are protected from extravasated matter by fresh sponges, the stomach and intestine are opened parallel and close to this suture line, and the interiors of each irrigated clean—the incisions should terminate opposite each other and about half an inch short of the extremities of the suture line. Having made the wounds and their surroundings clean and dry, the adjoining posterior margins of the two incisions are rapidly sewn together by a continuous suture passed through the entire thickness of the walls, and this suture is continued as far as possible around each angle of the incision and along the anterior margins. The operation is then completed by a row of Lambert sutures or a continuous suture extending along the anterior surface from one end to the other of the first suture line.

The constricting band at each extremity of the loop of intestine is then removed, all parts are made clean and dry, the surrounding sponge-packing is taken out and counted, the viscera replaced, and the abdominal wound closed tight in the usual way.

Some German surgeons, before uniting the stomach with the loop of small intestine, pass the latter through the great omentum and over the colon, or through a vertical slit in the transverse mesocolon and then through the gastrocolic ligament to the anterior surface of the stomach. But the route to the right, around the great omentum, is to be preferred whenever possible.

Jejunostomy for inoperable cancer of the pylorus has been performed a few times. A longitudinal incision is

made to the left of the umbilicus, the omentum and transverse colon pressed upward, and a loop of the upper portion of the jejunum brought into the wound and secured there by sutures as in gastrostomy. The opening made in the intestine should be only large enough to admit the tube through which food is to be introduced.

Maydl has proposed a more complicated method, as follows:

The abdomen is opened transversely about four finger-breadths below the ensiform process, a loop of jejunum some ten or twelve inches long extracted, and, with every antiseptic precaution, divided transversely. The proximal segment is then connected with the distal a few inches below the point of division by an anastomosis operation to preserve the biliary and pancreatic secretions, and the distal segment fixed in the abdominal wound as in gastrostomy,¹ or the distal segment may be attached to the stomach thus making a gastroenterostomy.

HERNIOTOMY, KELOTOMY.

Under this head are to be described the operations for the relief of strangulated *inguinal, femoral, umbilical, and obturator hernias*, and those for the radical cure of the first three varieties.

It has been well said that there is no operation in which the unforeseen has a larger share than in herniotomy, none in which the surgeon is called upon to show more skill, sagacity, and decision. The causes of this are to be found in the absence of absolute guides to the hernial sac, the changes in the sac and overlying tissues brought about by inflammation or time, the character of the hernia—whether composed of omentum, intestine, cecum, or bladder, and, lastly, the difficulty of determining not only the extent of the injury done to the strangulated tissues, but even, in some cases, the route taken by the hernia in its descent. It is desirable, therefore, that the account of the different operations should be preceded by some general considerations upon these subjects.

¹ Maydl - *Wien. med. Wochenscb.*, 1892, p. 697.

General Directions. A. Recognition of the Sac and Bowel. The first difficulty encountered in the course of the operation is that of recognizing the sac. The thickness of the connective tissue covering it varies greatly in different cases; each layer must be pinched up with forceps, opened with the knife lying upon its side, as in opening the sheath of an artery, then raised upon the finger or a director, and divided to the full extent of the cutaneous incision, after having been carefully scrutinized. Occasionally a cyst containing liquid is found in front of the hernia, and may at first be mistaken for it, for usually the sac contains a certain amount of serum. Careful examination of the tissues before division is absolutely necessary, because in those rare cases where there is no sac (hernia of the cæcum or of the bladder), and in others where it is quite undistinguishable, it is only by recognizing the muscular coat when he reaches it, that the surgeon avoids opening the intestine or bladder by mistake. As the sac is approached, each layer should be pinched up in a narrow fold and moved gently across the underlying parts; if a smooth globular tumor is felt below, the surgeon makes an opening in the fold, confident that the wall of the intestine is not included in it; but if he is unable to pinch up the fold, or if, instead of the sensation of a smooth globular mass, he gets only that of an empty space, he examines the surface again, divides any fibrous bands he may find at the neck of the hernia, and tries to introduce his finger through it into the abdominal cavity. If he succeeds, he knows the sac has been opened; if he does not succeed, he renews the examination and continues the dissection.

Maisonneuve said the surgeon may know he has not reached the intestine so long as he is not certain of having done so; but this is not true of all cases; the intestine is not always smooth and shining; it may be dark, dull, congested, and thickened, and in hernia of the cæcum or sigmoid flexure it may have no peritoneal coat.

When the hernia is small and recent the sac is bluish, and can be pinched up between the thumb and finger, so that its smooth opposing surface can be felt to glide upon one another. When it is large and of long standing, the sac may be exceedingly thin and unrecognizable, or very

thick and adherent. If small, it should be thoroughly isolated, and its boundaries everywhere defined; if large and adherent, its neck alone should be cleared.

B. Opening of the Sac. The propriety of opening the sac used to be a subject of dispute. The only objection to it, but that a serious one, was the danger of thereby setting up peritonitis. On the other side there was the danger of returning the hernia into the abdomen in a gangrenous condition, or unreduced when the stricture was formed by the sac itself. Now, however, the rule is always to open the sac with every antiseptic precaution and relieve any constriction which may be found by cutting down upon it layer by layer from without. Then either immediately or after an interval a radical cure is performed.

The liquid which is usually contained in the sac may not only serve to call attention to its accidental opening, but may also be taken advantage of to open it safely when it has been recognized. It, of course, collects at the most dependent point, and there intervenes between the sac and the bowel, so that the former can be pinched up and opened without injury to the latter. When this is not the case, the surgeon must pinch up a very small fold of the sac wherever he can do so, or do as Mr. Liston did in a case where, as he says, "there was no possibility of pinching up the sac, either with the finger or forceps; it contained no fluid, and was impacted most firmly with bowel; very luckily the membrane was there; and, observing a pelleton of fat underneath, I scratched very cautiously with the point of the knife in the unsupported hand, until a trifling puncture was made, sufficient to admit the blunt point of a narrow bistoury." The opening should be enlarged until the finger can be introduced, and then the sac slit up on it as a guide. If the omentum is then found filling the sac, it must be cautiously unfolded or incised, for it is probable, especially in umbilical hernia, that a strangulated loop of intestine will be found in its centre.

C. Division of the Stricture. The left forefinger is passed up into the neck of the sac by which the stricture is usually constituted, the pulp upward, the nail pressing

¹ *Op. Surgery*, p. 462, quoted by Jos. Bell, *Manual of Surgical Operations*, p. 231

against the intestines; if the stricture lies or can be drawn outside the opening in the abdominal wall through which the hernia made its escape, it may be divided freely without risk, but if it lies within the opening the division must be made with reference to the anatomy of the region. If the division cannot be made at the desired point, but only at some other where an incision of the necessary extent would be dangerous, the stricture must be slightly nicked at that point, and advantage then taken of the partial liberation to make a second cut in the proper place.

The end of the finger, or its nail, is gently engaged in the stricture, its pulp against the selected point of division, and the knife, a probe-pointed, slightly curved bistoury, passed on the flat along its palmar surface until the point has passed through the stricture. The surgeon then turns its edge upward and presses it against the stricture with the end of the finger on which it rests. A slight crackling announces the division, which must be extended or repeated at different points until the finger can be passed freely through into the abdomen.

Instead of an ordinary probe-pointed bistoury, a specially constructed hernia knife (Fig. 227) is often used. It is

FIG. 227.



Hernia knife

probe-pointed and its cutting edge not more than an inch long. The knife may also be guided upon a director instead of the finger. The "hernia director" is broader than the ordinary one, and sometimes has a broad flange on each side to keep the bowel from rolling over against the edge of the knife. It is, however, more surgical to cut down upon the constriction layer by layer and then divide it from without, the gut being protected by the finger or a director.

D. Examination and Return of the Bowel. The bowel

should be gently drawn out about an inch in order that the constricted part itself may be examined, for it is very likely to be badly damaged. If the entire loop is in suitable condition it must be carefully cleaned of all blood and gradually returned into the cavity of the abdomen. It is not always easy to decide, however, whether or not its condition is suitable for return, and some surgeons have recommended that in cases of doubt it should be covered with warm, wet cloths and kept under observation for some time, the stricture, of course, having been previously divided.

A very great change in the color of the loop is far from proving the existence of gangrene. A deep red vinous, even violet color does not preclude recovery, especially if the surface has not lost its lustre; but if it is black, or deep brown, or grayish-yellow, or if it is dull, flaccid, or wrinkled, it is certainly gangrenous. Of course, when the characteristic gangrenous odor, or the fecal odor consequent on perforation, exists, there can be no doubt.

If the loops are in good condition, but bound fast to one another, or to the omentum, or to the sac by firm adhesions, great caution must be exercised in dealing with them. The stricture must be freely divided and the loops emptied of their contents by pressure, and the adhesions, which have probably existed for a long time without inconvenience to the patient, should in most cases be carefully separated.

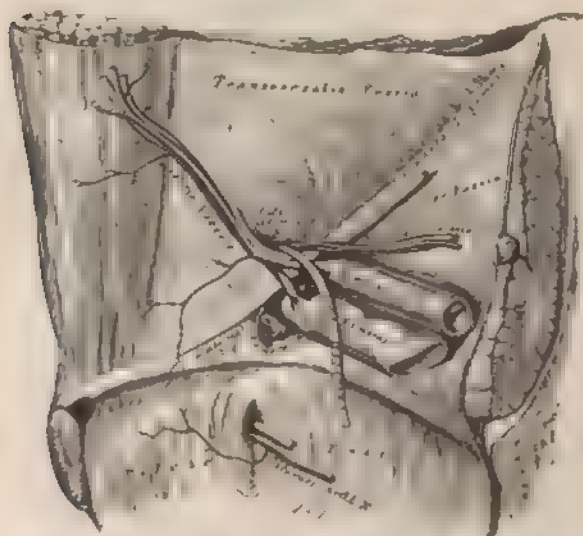
It is not always easy to return the intestines even after the stricture has been divided. The surgeon should try to reduce one end at a time, by squeezing its contents back into the abdomen and pushing the gut in afterward. If the bowel is very tense, and the hernial orifice cannot be freely enlarged, the gas may be drawn off with a fine aspirator. If rupture occurs, and the bowel is otherwise in good condition, it must be closed with *Lambert* sutures and returned into the abdomen.

If the intestine is gangrenous, an artificial anus must be formed, and it is well to stitch the bowel fast to the edges of the hernial ring, as in *enterostomy*. If the gangrene extends to the point of stricture and the bowel cannot be drawn further out, the stricture must not be divided, lest

the bowel should slip back and feces escape into the peritoneal cavity. The gangrenous portion must be incised, and then, if the feces pass freely, nothing more need be done, beyond taking measures to prevent the bowel from slipping back, such as making its edges fast to the sides of the incision, or passing a stout ligature through the mesentery and fastening it to the skin with adhesive plaster. But if the stricture still prevents the flow of feces, Gosse-
lin's plan of dilating it by introducing the finger into the intestine should be adopted.

E. *Treatment of the Omentum.* If only a small amount of omentum is found in the sac, and if it is in good condition, it may be returned; but if there is much of it, or if it

FIG. 22.

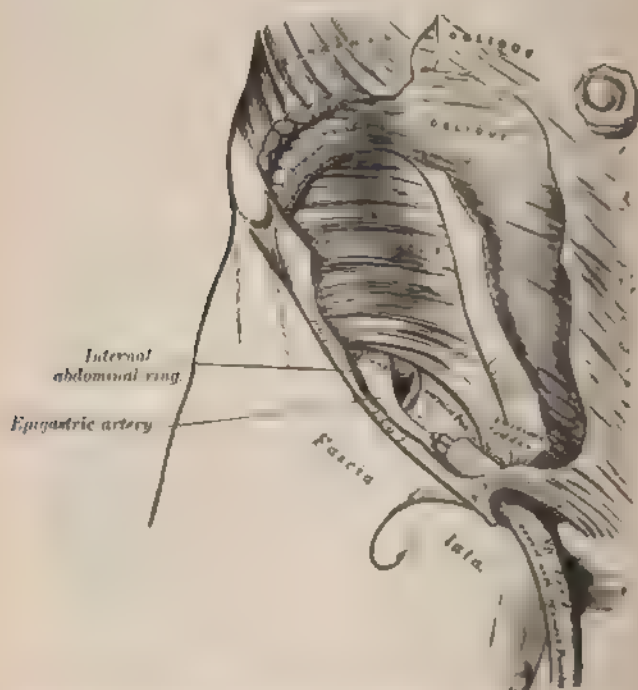


Hernia. The relations of the femoral and inguinal abdominal rings, seen from within the abdomen. Right side.

is inflamed, suppurating, or gangrenous, it must be kept out or incised, after its base has been transfixed in one or more places by double ligatures, which are then cut apart and tied.

Strangulated Inguinal Hernia. Inguinal hernia may be *oblique* or *direct*. The former leaves the abdomen at the internal (deep) abdominal ring, having the deep epigastric artery on the inner side (Fig. 228), passes down the inguinal canal, and emerges at the external abdominal ring (Fig. 229); the latter makes its way through Hesselbach's

FIG. 229.



Inguinal hernia showing the transversalis muscle, the transversalis fascia, and the internal abdominal ring.

triangle, a space bounded by the epigastric artery, Poupart's ligament, and the rectus abdominis muscle (Fig. 228), and also emerges at the external abdominal ring. The former is by far the more common variety.

Operation. The parts having been well shaved and

disinfected, the patient is anæsthetized and placed upon his back, with his shoulders slightly raised. The surgeon pinches up a broad fold of skin and subcutaneous tissue across the long axis of the swelling, transfixes it at its base with a straight bistoury, and cuts vertically through it, thus dividing most of the tissues without danger of injury to the sac or intestine; if necessary, this incision must be lengthened, so that its upper extremity will lie well above the external abdominal ring, and its lower extremity below the bottom of the hernial sac. The underlying layers are then pinched up one by one with the thumb and finger, or with fine forceps, and divided upon a director until the sac is reached and opened, every precaution being taken to avoid injury to the intestines. The best point for opening it is at its extreme lower end, because a little serum is usually collected there, separating it from the bowel. It must be pinched up, if possible, at the point selected, and an opening made with the knife held flat against it; a director or the finger is then passed through the opening, and the full length of the sac slit up. The constriction is then sought for, and, if found above the external ring, must be nicked or divided directly upward, or cut down upon from without.

If it can be positively made out that the hernia is of the *oblique* variety, the cutting should be done on the outer side, for the epigastric artery lies close to the inner side of the internal ring, through which this variety passes; and if it is known to be of the *direct* variety, the cutting must be done upon the inner side. But, unfortunately, in most cases the dragging of the hernia brings the two rings immediately opposite each other, so that the inguinal canal can no longer be said to exist, and the diagnosis cannot be made with certainty. The incision must then be made upward, parallel to the course of the epigastric artery.

The intestine must next be examined to ascertain if it is in a fit condition to be returned; and here it must not be forgotten to draw down an inch or more of each end so that the part which has undergone constriction may also be examined. If the condition is satisfactory, the bowel is returned gradually, not *en masse*, and the wound closed by one of the methods about to be described for radical cure,

preferably Bassini's. If it cannot be safely returned, it is resected or fastened in the wound, as in enterostomy.

Strangulated Femoral Hernia. The intestine in its descent occupies a canal which begins at the femoral ring under Poupart's ligament, between the free arched border of Gimbernat's ligament and the femoral vessels (Fig. 228), and ends at the saphenous opening in the fascia lata of the thigh. After passing through the opening it turns upward over the groin. The normal length of the canal is about an inch, but in hernias of long standing it is much shortened by the approximation of its two ends. The seat of stricture is now thought to lie in most cases at the saphenous opening, or just above it, and not at the base of Gimbernat's ligament, as was formerly supposed; free division is possible at the former point on the upper and inner side without the risk of injury to any organ, except possibly the spermatic cord, and that is at such a distance as to be practically out of harm's way. Under ordinary circumstances, Gimbernat's ligament can also be safely divided on the inner side, but in about one and one-half per cent. of cases the obturator artery pursues the anomalous course shown in Fig. 230, and then lies directly in the way of the

FIG. 230



Variations in origin and course of obturator artery

knife. The neck of the sac under such circumstances is entirely surrounded; on its outer side are femoral vessels, above are the spermatic cord and common trunk of the epigastric and obturator arteries, on its inner side the obturator artery, below it the bone. The only safe plan of relieving the stricture, therefore, is to nick it slightly, to

the depth of one or two millimetres, at several points on its upper and inner borders. The coverings of the hernia are thin and composed of the skin, subcutaneous tissue, cribriform fascia sometimes, septum crurale, and peritoneum.

The incision may be straight or curved, the convexity directed downward and outward, or T-shaped, the horizontal branch being made along Poupart's ligament, the other passing directly downward over the saphenous opening, and should be made from without inward. The single vertical incision just to the inner side of the femoral vessels is the one usually employed. The underlying tissues must be divided, and the sac exposed or opened in the manner described under *General Directions*, and the seat of stricture sought for and divided according to the rules above laid down.

The gut is then pulled down and examined, and if its condition is satisfactory it is returned and a radical cure performed. If not, it is resected or fastened in the wound. Femoral epiplocele is treated like the inguinal.

Strangulated Umbilical Hernia. It is generally claimed that true umbilical hernia, that is, hernia through the umbilical ring, is almost always congenital, and that the hernias which occur during adult life emerge, not through the ring, but through an accidental opening in the linea alba near it, and therefore deserve the name of *peri-umbilical* given them by Gosselin. While this condition, that is, of escape through a chance opening in the linea alba, may exist in some cases, Richet¹ has sought to prove by anatomical considerations and by the results of the examination of three cases of hernia, that true umbilical hernia, on the contrary, is the rule, and the other is the exception. He shows that the weak point of the ring is its upper portion, and that when the cicatrix is pressed downward and given a semicircular form by the hernia, a complete ring, which seems to be situated above that corresponding to the vein and arteries, is constituted by the cicatrix below and the upper part of the opening above, and exactly resembles a distended accidental perforation.

¹ Anatomie Médico-Chirurgicale, Part II. p. 378.

The peritoneum is much more adherent to the abdominal wall in the umbilical than it is in the inguinal region, and, consequently, the sac of a hernia, being formed by the distention of a small portion of peritoneum, is exceedingly thin, in fact its existence has been denied. The coverings of the hernia are the skin, cellular tissue, and peritoneum; its contents are the small intestine, sometimes the transverse colon, and in the adult the omentum.

On account of the pathological changes which take place in the sac and its contents, it is best to undertake a formal laparotomy if the hernia is strangulated or irreducible. An incision is made gently curving outward around one side of the base of the hernial tumor, and prolonged a couple of inches above and below it in the median line. The incision is deepened layer by layer and the peritoneum opened in the median line above and below the neck of the hernial sac, and in the intermediate space divided on the finger as a guide, in the line of the cutaneous incision close outside the neck of the sac, sparing the margin of the rectus muscle as much as possible. A sponge protective packing is placed on the surrounding viscera, and an incision is made through the neck and body of the sac, including the overlying skin, at right angles to the centre of the curved incision around the base of the hernial tumor, exposing the hernial contents without damaging them.

The constriction is thus relieved, and the dissection is continued till the hernial contents are freed from adhesions to each other and the sac. If they consist of omentum alone, the excess is excised on the proximal side of the strangulation and the abdominal wound treated as described below. If of intestine, the gut is surrounded by warm cloths or placed in the abdomen on the sponge protectives. Then the hernial sac, together with the overlying skin and the umbilicus, is excised with division of the peritoneum close around the neck of the sac.

The intestine is next inspected, and if gangrene is present the gut is resected or left outside the partially closed abdominal wound for the slough to separate. A couple of Lembert sutures, or a stout silk loop through the mesentery, serve to retain the healthy part above and below the damaged area in the margins of the wound.

If the gut is healthy, after excision of the excess of omentum and of the sac with its overlying skin and umbilicus, the sponge protective packing is removed, the edges of the sheaths of the recti muscles are freshened, and the abdominal wound closed in the usual way with close approximation of the recti. The wound is then dressed in the ordinary manner.

Strangulated Obturator Hernia. A long incision is made parallel to the femoral vessels and about an inch away from them on the inner side. The pectineus muscle is exposed and divided, as are also any fibres of the obturator externus whose division may be necessary to give access to the seat of the stricture. The relations of the artery and nerve to the neck of the sac must be determined, and the division made in such a direction that they will not be injured.

If the gut can be returned into the abdomen a radical cure can then be attempted. This consists simply in isolation of the sac, its ligation as high as possible after reduction of the hernia, excision of the distal portion, closure of the orifice with silkworm-gut, and suture of the wound in the overlying soft parts.

The same may be said of hernia occurring in such unusual localities as Petit's triangle, the great sacrosciatic foramen, etc.

If the gut is gangrenous it must be fastened in the wound as in enterostomy or resected, provided the condition of the patient permits.

RADICAL CURE OF INGUINAL HERNIA.

*Cerny's Operation.*¹ An incision is made three or four inches long over the inguinal canal and upper end of the hernial sac, with its centre opposite the external abdominal ring. The aponeurosis of the external oblique muscle and the sac are exposed, and the neck of the latter dissected free from the surrounding parts. This is most easily done after the body of the sac has been opened and the hernial

¹ *Wien. med. Woch.* 1877, No. 21.

contents freed from adhesions and reduced, and one finger passed through the interior of the neck of the sac to make it tense and serve as a guide in the dissection.

The neck of the sac is drawn down and tied off as high up as possible or at the internal abdominal ring, with a stout catgut ligature, which is drawn tight over the tip of the finger placed inside the neck to prevent prolapse of the hernia and its inclusion in the ligature. Czerny drew the serous surface together by a continuous (purse-string) silk suture passed from the inside. The sac distal to the ligature is excised, though any part or the whole of it can be left undisturbed if it seem advisable.

The sides of the opening in the abdominal wall are drawn together with catgut or silkworm-gut sutures passed through all the layers between the skin and peritoneum, and closed over the cord, which is left to emerge through as small an opening as possible at the lower angle of the suture line. The skin wound is closed with interrupted fine silk sutures, and if it seem necessary a strip of rubber tissue is placed in the lower angle of the wound for drainage.

Ball¹ applied torsion to the sac and its neck before ligating and excising the distal portion. Barker² dissects out and divides the neck of the sac, transfixes and ties it off with a silk ligature, and then uses the long ends of the latter as a suture to close the internal ring and overlying wound. He does not remove the body of the sac. The rest of the wound is closed by both as in Czerny's operation. Macewen³ dissects out the sac, its neck, and the immediately adjoining peritoneum. He then inverts and reinverts the apex of the sac into its neck, transfixes and ties together with a firm catgut or silk ligature the mass thus formed and fastens it on the inner surface of the internal abdominal ring. The latter is closed by suturing the conjoined tendon to the inner surface of Poupart's ligament. The external ring is narrowed as much as possible by silkworm-gut stitches and the cutaneous wound united over it.

¹ Brit. Med. Jour., 1887, 1, p. 172.

² Ibid. 1, 123.

³ Ibid. p. 123.

The main feature of the last three operations is the attempt to obliterate the funnel-shaped depression leading into the neck of the hernial sac and to substitute at this point an elevation.

Kocher's¹ method has yielded excellent results, and is as follows: An incision three or four inches long is made in the long axis of the hernial tumor; its centre is over the external ring; only the skin and subcutaneous tissue are divided; none of the external oblique muscle is cut. After dissecting out the body and neck of the sac up to the internal abdominal ring and reducing the hernia, a finger is passed up the inguinal canal and on its tip as a director an artery clamp is forced through the external and internal oblique and transversalis muscles at a point about half an inch to the outer side of the internal ring. Without removing it from the puncture the clamp is passed on down the inguinal canal and made to seize the apex of the sac, which is then drawn up and pulled through the puncture and twisted into a round cord. The latter is laid upon the outer surface of the external oblique and lower down in the inguinal canal and secured there by five or six sutures passed through all the structures (except the skin, subcutaneous tissue, and peritoneum) on each side of the inguinal canal. The last one or two sutures through the extremity of the twisted sac and the pillars of the external ring draw the latter together. The cutaneous wound is then closed and dressed antiseptically.

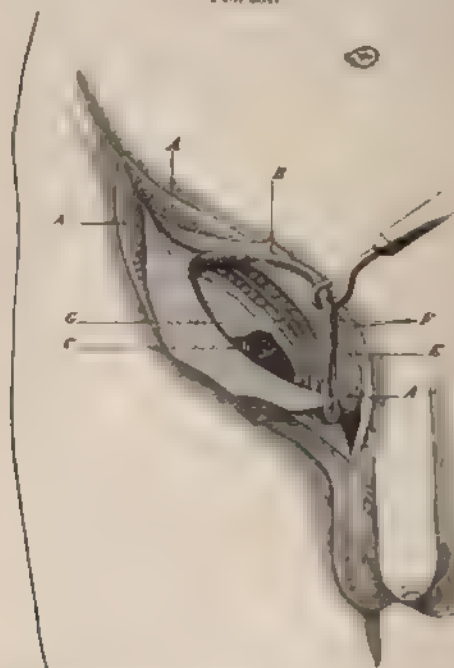
*Bassini's Operation.*² An incision three or four inches long is made from the level of the upper part of the internal abdominal ring obliquely downward over the long axis of the hernial tumor. The aponeurosis of the external oblique muscle is exposed and divided from the upper border of the internal abdominal ring over the whole length of the inguinal canal, and the neck of the hernial sac isolated from the cord and surrounding parts. (Fig. 231.) The body of the sac is nicked and opened sufficiently to free its contents from possible adhesions, and to permit reduction of the hernia by a finger passed through the

¹ *Annals Surg.*, 1892, vol. 16, p. 506.

² *Centralb. f. Chir.*, 1899, vol. 40, p. 429.

interior of the neck of the sac to its abdominal orifice. The neck is then drawn down, dissected free, and encircled or transfixed as high up as possible by a stout catgut ligature, which is drawn tight over the tip of the finger still

FIG. 231.



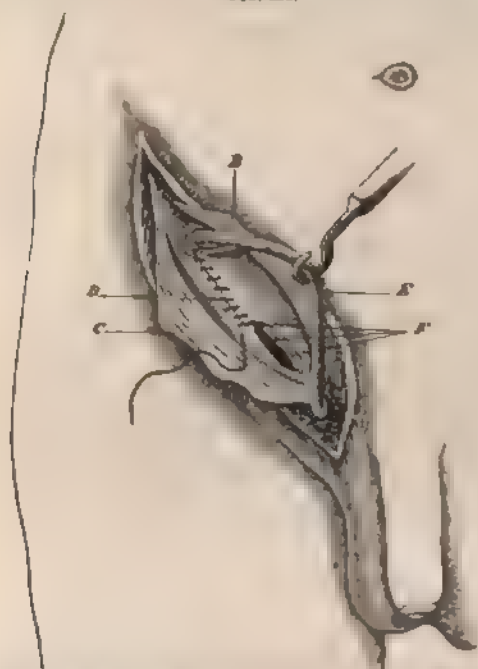
- A, A, A* Subcutaneous cellular tissue
B Spermatic cord
B, C Aponeurosis of external oblique divided and turned back
D Epigastric vessels
E Internal oblique and transversalis muscles and vertical fascia of Cooper

kept inside the neck of the sac to prevent the prolapse of any viscus and its inclusion in the ligature. The lower portion of the sac is then dissected out and excised.

The margins of the wound, including the divided aponeurosis of the external oblique muscle, are well retracted, and on the outer side of the internal abdominal ring and

inguinal canal, the upper border of Poupart's ligament is exposed, and on the inner side the conjoined edge of the internal oblique and transversalis muscles and the transversalis fascia. After raising the cord these structures on the inner side of the internal abdominal ring and inguinal canal are united beneath the cord to Poupart's ligament

FIG. 232.



Suture of the conjoined tendon and transversalis fascia (F) to the posterior border of Poupart's ligament (D).

E. The cord.

B, C. Aponeurosis of the external oblique.

by interrupted silkworm-gut sutures extending upward from the crest of the pubes till only enough space in the upper and outer part of the internal abdominal ring is left for the cord to pass without undue compression. The lower two sutures should include the outer border of the rectus muscle. (Fig. 232.)

The cord is then placed on this new posterior wall of the inguinal canal and the divided aponeurosis of the external oblique muscle united over it by interrupted silkworm-gut sutures, leaving as small an aperture as possible at the lower angle for the cord to emerge. (Fig. 233.) The skin

FIG. 233



Suture of the divided aponeurosis of the external oblique (A, C) over the spermatic cord (B).

wound is sutured with interrupted silk and dressed antiseptically without drainage, and in children it is wise to add a plaster-of-Paris spica.

Bassini uses silk for the buried sutures and forms the new internal abdominal ring about half an inch to the inner side of the anterior superior spine of the ilium; that is, he divides the internal oblique and transversalis muscles above and to the outer side of the internal abdominal ring, trans-

plants the cord to the outer extremity of this incision, fastens the internal oblique and transversalis under it and the external oblique over it. If the hernia is complicated by undescended testicle Bassini unfolds the vas deferens by a careful dissection and brings the testicle down from the inguinal canal and sutures it to the bottom of the scrotum. If this is impossible castration is performed.

Lauenstein places the testicle in the abdomen along with the stump of the sac. In congenital hernia enough of the fundus of the sac is left to form a tunica vaginalis.

FIG. 234.



FIG. 235.



FIG. 236.



Method of tying off omentum in sections.

In direct inguinal hernia the orifice of the hernia is formed by the external abdominal ring, the neck of the sac is short and passes over the cord and lies to the inner side of the deep epigastric artery. As the hernia increases in size the neck of the sac comes to overlap the artery, and thus in time may pass on both sides of it and contain the artery. After tying off the neck of the sac of a direct inguinal hernia, the parts on the inner side of the abdominal orifice, between the peritoneum and external oblique tendon, are sutured, as in the indirect variety, to Poupart's ligament.

If the hernia is an epiplocele the excess of omentum is tied off with stout catgut close to the neck of the sac and excised. If it is very large, the pedicle should be spread out and tied in sections, as illustrated in Figs. 234, 235, 236.

Halsted's operation¹ is as follows: The aponeurosis of the external oblique and the external abdominal ring are exposed by an incision starting some 5 centimetres above and external to the internal ring and extending to the spine of the pubes. In this line the aponeurosis of the external oblique and the fibres of the internal oblique and transversalis muscles and the transversalis fascia are cut from the external ring to a point about 2 centimetres above and external to the internal ring. The peritoneum and neck of sac are thus exposed, the latter opened, the hernia reduced, and the neck of the sac ligated or sutured and the distal portion excised. The cord is then isolated, and, after removing all but one or two of its veins, it is transplanted to the outer angle of the incision. Beneath it mattress sutures are passed: on the inner side through the aponeurosis of the external oblique, the internal oblique and transversalis muscles, and transversalis fascia; on the outer side through the aponeurosis of the external oblique, Poupart's ligament, and the transversalis fascia. This obliterates the canal and places the cord on the outer surface of the external oblique aponeurosis, where it is covered by skin and subcutaneous tissue only. The cutaneous wound is then closed by superficial sutures and dressed antiseptically without drainage.

M'BURNEY'S OPERATION.²

The incision, division of the aponeurosis of the external oblique muscle, and the treatment of the sac are the same as in Bassini's operation.

Sutures are then passed through the skin, the aponeurosis of the external oblique (including the inner pillar of the external ring), and the conjoined tendon firmly binding

¹ *Annals of Surgery*, 1893, vol. 17, p. 502.

² *New York Medical Record*, 1899, vol. 35, p. 312.

these structures together with deep inversion of the skin. On the opposite side of the wound the skin is inverted and sutured to Poupart's ligament, including at the lower part the outer pillar of the external ring; the lower angle of the wound is sutured with silk over the cord and drawn together above with two or more tension sutures passed through the skin and superficial fascia and tied over pledgets of iodoform gauze. The space of about one-fifth of an inch left between the lips of the wound is packed snugly with iodoform gauze down to the peritoneum to insure healing by granulation and the obliteration of the inguinal canal by dense cicatricial tissue. This operation was at first extensively used, but of late has largely yielded place to Bassini's; it is, however, a safer and surer operation for the less experienced.

Radical Cure of Umbilical Hernia. If the hernia is irreducible, the treatment is the same as that described for strangulated umbilical hernia.

If reducible, an incision is made which encircles the base of the hernial tumor, extending an inch or two above and below it in the median line, and deepened layer by layer till the abdominal cavity is opened at one extremity of the incision. A flat sponge is inserted, and on the finger as a guide the peritoneum is divided in the line of the cutaneous incision around the neck of the sac, and the latter excised together with the body of the sac, the overlying skin, and the umbilicus. The peritoneum is then sutured with catgut, the sponge being removed before the last stitch is tied; the edges of the sheaths of the separated recti muscles are freshened throughout the whole length of the wound, and the recti closely approximated with interrupted catgut or silkworm-gut sutures. Over this the superficial fascia and skin are united with silk after excision of any redundant portions.

Radical Cure of Femoral Hernia. Starting from Poupart's ligament a vertical incision some three or four inches long is made just to the inner side of the femoral vessels. It must be deepened carefully, as the coverings of the hernia may be very thin and consist only of skin and superficial fascia if the hernia has passed through the cribriform

fascia. After exposing and opening the sac and returning the bowel or possibly excising the omentum, the neck of the sac is isolated and tied off high up with silk or stout catgut.

Various procedures have been adopted for the succeeding steps in the operation. Billroth removed the portion of the sac distal to the ligature and sutured the middle third of Poupart's ligament to the fascia covering the abductor muscles, or to that on the inner aspect of the femoral vessels. Berger united Poupart's ligament to the pubic portion of the fascia lata covering the pectineus muscle. A flap cut from the latter muscle has been turned up and fastened in the femoral ring.

Macewen employs the same principle as for the cure of inguinal hernia (*q. v.*); i. e., the sac is folded into a pad and secured on the inner surface of the femoral ring, which is then drawn together with silk or silkworm gut passed through the available soft parts adjoining its boundaries. Kocher exposes the sac and saphenous opening by a vertical incision, but does not divide the fascia lata overlying the canal; the sac is then drawn through a puncture in Poupart's ligament just over the canal, twisted, and its extremity brought down over the ligament into the canal again, and secured there by two or three silk sutures passed through it and Poupart's ligament and the pectineal fascia.

After obliterating the track of the hernia by whatever method is adopted, the external wound is closed and dressed antiseptically.

RECTUM.

Anatomy. The rectum is from six to eight inches long, and for about its first three inches is covered by peritoneum and supplied with a mesorectum. In front the peritoneum descends to within about three inches, and behind about five inches from the anus. The second portion of the rectum is in relation in front, in the male, with the trigonum of the bladder, the vesiculæ seminales, and the vasa deferentia and the prostate, the posterior margin of which can normally be reached by the finger. In the female this

portion of the rectum is attached to the posterior vaginal wall.

Below the prostate the levatores ani join the rectum from one and a half to two inches from the anus, at a point just above the internal sphincter. The superior hemorrhoidal artery lies on the outer surface of the rectum behind, a little to the left of the middle line, till within about four inches of the anus. It then divides into its terminal branches, which have a longitudinal distribution between the mucous and muscular coats and communicate freely about the anus.

The veins have a similar distribution, and communicate through the superior hemorrhoidal with the portal system, and through the middle and inferior hemorrhoidal with the internal iliac veins. The sphincter is supplied by the fourth sacral nerve.

IMPERFORATE ANUS OR RECTUM.

In order to understand their different congenital deformities, it is essential to bear in mind the manner in which the rectum and anus are developed. The rectum, like the rest of the intestine, is formed by the third blastodermic layer of the ovule, and originally communicates with the pedicle of the allantoid vesicle, that which afterward becomes the bladder and the posterior portion of the urethra. The anus, on the other hand, is formed by a dimple in the outer blastodermic layer, the one which forms the epidermis. In the ordinary course of events the communication between the rectum and the bladder or urethra closes, and another forms between the rectum and anus by absorption of the layer of tissue between them. The malformations are the result of arrest of development of the colon, rectum, or anus, or of the persistence of the septum, and present several varieties.

The first, and slightest, is not a true arrest of development, but a simple closure of the orifice of the anus by a tegumentary layer or by adhesion of its sides, the deep communication between it and the rectum being complete.

This requires only separation of the adherent edges with a director, or division of the layer with a knife.

2. The rectum and anus may be fully developed, but the thin membranous diaphragm between them may persist, like the hymen in the vagina. The treatment of this also is simple: crucial incision or large puncture of the membrane.

3. The anus may be entirely absent, while the rectum is normally developed; the distance between the lower end of the latter and the surface being from half an inch to an inch.

4. The anal cul-de-sac being properly developed, the rectum or colon may terminate at any distance above it, or may even not exist at all, being represented by a fibrous cord extending from the ileo-cæcal valve to the anus.

5. The arrest of development may involve both the anus and the rectum.

6. The rectum may open into the bladder, urethra, or vagina.

It is often exceedingly difficult to determine the character of the malformation during life, and yet it is very important that this should be done, for if the imperviousness begins at a point too high up to be reached through the perineum, the only possibility of relief is in the establishment of an artificial anus in the lumbar or inguinal region. Depaul¹ says that when the obstruction begins at the ileo-cæcal valve the transverse distention of the abdomen is much less than in rectal obstruction.

If the surgeon decides to go in search of the blind end of the rectum and create an anus in the perineum, he must make an incision in the median line from the scrotum to the tip of the coccyx, after having previously introduced a sound into the bladder if the patient is a boy, or into the vagina if a girl. He then divides the tissues layer by layer in the line of the incision, feeling at each step for the distended rectum, which can sometimes be seen and felt to bulge downward when the child strains or cries. Or an exploratory puncture may be made, and the needle or trocar used as a guide if the bowel is reached by it.

¹ Bull. de la Société de Chirurgie, 1877, p. 586.

The search for the bowel should be made in the direction of the axis of the anal cul-de-sac, if the latter is sufficiently developed, and advantage taken of the fact pointed out by M. Forget,¹ that a fibrous cord, representing a rudimentary portion of the rectum, occupies more or less of the distance separating the two. If, on the contrary, the anus is lacking, the search must be made toward the concavity of the sacrum. Verneuil has proposed to excise the coccyx, so as to diminish the danger incurred during the search, but as this is followed by prolapse of the rectum it should be practised only when a simple incision has proved insufficient.

When the end of the bowel is reached it must be seized with pronged forceps, or two stout ligatures must be passed through it, and it must be partly separated from the adjoining tissues, drawn down, opened, and made fast to the integument or the margin of the anus. The anterior and posterior portions of the cutaneous incision must finally be closed by sutures. It would be perfectly proper when in doubt as to the presence or position of the rectum to open the abdomen in the median line or the left inguinal region, and then, after ascertaining the conditions, if necessary perform a colotomy.

When the rectum opens into the vagina it may be reached through a longitudinal or crucial incision in the perineum, separated from the vaginal wall with a knife or curved scissors, and drawn down and fastened as before. The former opening will then close spontaneously.

PROLAPSE OF THE RECTUM.

The mucous membrane of the rectum is very loosely attached to the muscular coat, and when the sphincter is relaxed or disabled prolapse may occur to a degree that requires operative interference. This interference may involve the mucous membrane alone, or it may also include the anus or the entire rectum. In the first case the indication is to promote adhesions between the mucous and mus-

¹ *Bull. de la Société de Chirurgie*, 1863 and 1877.

cular coats, or to remove portions that may be in excess ; in the second to narrow the anal orifice. The former is accomplished by making deep longitudinal incisions through the mucous membrane, or by pinching up folds at three or four different points and tying a strong ligature about each. The incisions are likely to give rise to severe hemorrhage, and consequently the method has fallen into disuse ; the actual cautery, however, applied at points or in lines, has been used as a substitute as follows :

In a slight or partial prolapse the bowels are emptied in advance and the parts reduced and put on the stretch with the bivalve speculum. The point of a Pasquelin cautery is drawn the whole length of the prolapse in four longitudinal lines about a quarter of an inch wide and equally distant from each other, without destroying the entire thickness of the mucous membrane. To avoid penetrating too deeply Cripps advises that the cautery be used at a black heat only. If the skin about the anus is not touched the after-pain is slight. A tube reaching above the sphincter is inserted to give exit to flatus, while the bowels are kept confined for several days. For several weeks thereafter the patient must defecate in the recumbent position and avoid straining efforts, while the adhesions caused by the cauterization become firm between the mucous and muscular coats.

There are two methods of narrowing the anal orifice. Dupuytren pinched up with forceps several of the radiating folds of integument and cut them off with curved scissors, trusting to cicatricial retraction for the narrowing he desired.

Robert made two incisions, extending from the extremities of the transverse diameter of the anus to the tip of the coccyx, removed the skin, subcutaneous tissue, and portion of the sphincter contained within the V thus marked out, and brought the sides of the gap together with sutures.

Rectopexy. In cases of extensive prolapse the rectum has been returned into the abdomen and secured in the concavity of the sacrum behind or to the abdominal wall in front or in the left inguinal region.

For the first procedure an incision is made in the median line from just behind the anus to the tip of the coccyx, and deepened backward and upward till the concavity of the

sacrum is reached. A catgut suture is then passed through the fibrous tissue in front of this bone, and through the back of the rectum without entering its lumen, and the wound either closed immediately or after two or three days, during which it is lightly packed.

To secure the rectum to the anterior abdominal wall, the peritoneal cavity is opened in the median line just above the pubes with every antiseptic precaution, and the gut secured at the peritoneal aspect of the wound, as in hysteropexy, by a silk suture passed through the whole thickness of the abdominal wall, and the anterior longitudinal band of muscular fibres in the rectum. The lumen of the latter, of course, must not be entered.

In the left inguinal region the abdomen is opened as for colotomy, and the upper end of the rectum fastened to the inner surface of the wound in a similar manner, or by a suture passed through the whole thickness of the mesorectum and parietal peritoneum.¹

Ablation. For pronounced cases with gangrene present or threatening Treves² divides the rectum circularly layer by layer at the muco-cutaneous junction, taking care to avoid injury to any small intestine which may have become herniated into the pouch formed by the prolapse. The cut edges of the skin and intestinal mucous membrane are then united with catgut. If the peritoneum is opened the wound must be immediately closed with Lembert sutures.

Torsion. When the sphincter has been destroyed or removed Gerster³ supplies a substitute by twisting the rectum on its long axis till its walls form a rather close spiral. After isolating some two to five inches of its lower end the gut is turned through about half a circle or more, and its free extremity sutured to the margin of the skin.

Rectotomy. There is occasionally found, especially in women, a form of stricture occupying the lumen of the rectum like a thin perforated diaphragm, which is probably

¹ Berg. *Annals Surg.* 1908, vol. xvi. p. 375.

² *Lancet*, 1906, vol. i. p. 152.

³ *Annals Surg.* 1894, vol. xix. p. 612.

the result of a partial persistence of the fetal membrane between the anal portion which is developed from below upward by the dimpling of the skin, and the rectal portion which comes down from above to meet it. For the treatment of this, after emptying the bowels, the sphincter is first very thoroughly dilated and then a blunt director is forced through the wall of the rectum in the posterior median line below the stricture and brought back into the rectum in the same line above it. By hooking the finger or a loop of stout wire over the point of the director the stricture can be drawn down within reach from the anus and divided layer by layer, and all bleeding points secured with ligatures. A drainage tube and light packing are passed through the anus to the point of division.

Strictures more extensive than these, yet not suitable for excision, are divided with the knife or cantery in the median line posteriorly carrying the division through the rectal wall below the stricture, and the sphincter toward the coccyx, to secure the most perfect drainage possible. A tube and packing are placed in the incision.

FISTULA.

After thoroughly dilating the sphincter a blunt director is passed from without till its point is felt within the rectum, or if no aperture exists it is thrust through the mucous membrane where the least tissue intervenes.

The point is then pulled down out of the rectum, or, if this is impossible, the anus is held open with a speculum, and the parts on the director divided at right angles to the anal margin. If there is no external orifice, the director is bent to a sharp angle and passed with the assistance of the speculum from the internal opening, the skin incised on its point and the parts on the director cut as before. Sinuses in all directions must be slit up and granulations scraped away. Multiple fistulae should be opened into each other if possible, and if more than a single complete division of the sphincter is necessary one division should be allowed to heal before the next is made. In women the sphincter decussates in front with the sphincter vaginae and cannot

be completely divided at this point without considerable loss of power.

HEMORRHOIDS.

Ligation. Concerning the treatment of hemorrhoids by ligation there are a few points which deserve mention. The sphincter should be temporarily paralyzed by forcible dilatation. Every pile that is more than half an inch in diameter must be transfixed by a needle carrying a double ligature, and then strangulated by tying it at its base; the smaller piles do not need to be transfixed, it is sufficient to throw a single ligature about each. When the tegumentary margin is to be included in the ligature it should be cut through it with scissors. The ends of the ligatures should not be cut off as soon as they are tied, but after three or four have been placed at opposite points of the circumference, it will be found easy to get an excellent view of the interior by drawing them outward and apart. The temporary paralysis of the sphincter not only facilitates the examination and operation, but it spares the patient pain during convalescence.

*Whithead's Operation.*¹ The sphincter is well dilated, and the mucous membrane starting posteriorly is divided at its junction with the skin by blunt-pointed scissors around the entire circumference of the bowel. It is dissected up with the dilated veins to the internal sphincter, or till all the pile-bearing mucous membrane is drawn outside of the anus. The mucous membrane is then divided transversely by short snips of the scissors close to its still attached upper border, and each part as it is cut sutured to the edge of the skin. The vessels are secured as they are divided.

EXCISION OF THE ANUS AND PART OF THE RECTUM.

This operation may be rendered necessary by disease otherwise incurable. The resulting condition is seldom satisfactory, owing to the loss of the sphincter if the anus is

¹ British Medical Journal, 1867, vol. i. p. 449.

excised, and its almost certain paralysis from injury to the nerves during the manipulation, if the anus is left. It must be remembered that the peritoneum descends upon the anterior surface of the rectum to within about an inch of the prostate, but not quite so far upon the sides or behind; its average distance from the anus is from two to two and one-half inches in front and five inches behind. If the upper limit of the tumor on the posterior side cannot be reached by the end of the finger introduced through the anus, its removal should not be attempted from below. The nature and extent of its connections with the important organs on the anterior surface must also, of course, be carefully determined.

A. *Removal from below of the Anus and Part of the Rectum.* Two curved incisions, meeting in front and behind in the median line, are made through the skin, one on each side of the anus, and at a distance of about one inch from it. They are carried down to the rectum, remaining, of course, external to the neoplasm if it has broken through the rectal wall, and the rectum is then dissected upward as far as necessary, using the fingers instead of the knife for this purpose whenever possible. A sound should be introduced into the bladder as a guide if the patient is a man, and a finger into the vagina if the patient is a woman. When the upper limit of the tumor is reached, the rectum is drawn well down, its posterior wall divided longitudinally, and the diseased portion removed.

If the disease extends upward more than one and a half inches, it is advisable to prolong the incision backward to the tip of the coccyx, and perhaps even along the side of this bone.

Velpeau took the precaution to pass a number of threads through the intestine above the proposed line of excision, bringing them out through the skin beyond the external limits of the disease. After the removal of the tumor, he had only to tighten and tie these threads to bring the edges of the incisions through the intestine and the skin together.

Richard Volkmann¹ has modified this operation somewhat

¹ Ueber den Mastdarmkrebs und die Exstirpation recti in Klinischen Vorträge, No. 181 (Chirurgie, No. 42), p. 1113, 13th March, 1873.

and claims that by thorough drainage and the strictest attention to disinfection of the wound during and after the operation, excision of the rectum can be carried to a very considerable height, and even the peritoneal cavity opened, without danger to the patient. He empties the bowel thoroughly, makes a circular incision about the anus, a straight one in the median line back from the circular one to the osceyx, and, if necessary, another in the median line of the perineum; the bowel itself must not be cut into. He then draws the rectum down, dissects it out circularly to the necessary height, passes ligatures through the healthy portion after Velpeau's plan, and cuts off the lower portion containing the tumor. Bleeding points are temporarily secured by self-retaining forceps, and afterward with catgut.

If the peritoneal cavity is opened, a sponge soaked in a salicylic acid or thymol solution is kept pressed against the opening, until the excision is completed; then if the opening is small its edges are drawn out with artery forceps, and a ligature thrown around it as if it was a vessel; if it is large, it is closed with catgut sutures.


The upper end of the gut is then drawn down and fastened to the skin very accurately with alternate deep and superficial sutures, two or three drainage tubes are inserted, cut off close to the surface, and stitched fast.

During the operation, the bleeding surface is constantly protected against infection by irrigation with an antiseptic solution, and for the first three or four days constant antiseptic irrigation is kept up through a tube passed well into the wound near one of the drainage tubes; daily antiseptic injections are afterward made through the drainage tubes until the wound has healed.

Volkman claims that these precautions strictly carried out insure the patient against the chief danger of the operation, that of exciting diffuse pelvic cellular inflammation, which spreads rapidly upward behind the peritoneum, and causes death by septic peritonitis. Although the bleeding during the operation is very severe, he has never known it to have fatal consequences.

He thinks, also, that cancer is much less likely to return locally after excision of the anus than it is when the sphincters are preserved, and, therefore, he prefers total excision

of the anus and of the rectum to the upper limit of the disease, even when the anus itself is not involved.

I must add that the best result in my experience or observation, freedom from recurrence that has now lasted for seven years, followed removal of the tumor alone, a mass two and a half inches in diameter on the posterior wall of the rectum, and beginning one and a half inches above the anus. After dilatation of the sphincter I made an incision through it in the posterior median line up to the tumor, and cut the latter out with scissors, keeping one-third inch from it all around. The bleeding was free, but the vessels were readily secured. The sides of the gap were drawn together in the form of , the longitudinal incision closed with sutures, and a drainage tube placed behind the bowel and brought out at the posterior angle of the incision.

B. *Resection of the Rectum from below, leaving the Sphincter.* After thoroughly emptying the bowels in advance the patient is placed in the lithotomy position, or on the side with the hips and knees flexed. An incision is made in the median line posteriorly through the anus and rectal wall below the disease, and carried to the coccyx. With a sound in the urethra or finger in the vagina, another incision in the median line in front is carried through the anus and lower healthy rectal wall into the perineum. The buttocks are separated and the lips of these incisions drawn apart with blunt retractors.

The sound rectum is then divided transversely below the disease and above the sphincter by lateral incisions joining the upper extremities of the incisions through its anterior and posterior walls. By working with the fingers and blunt-pointed scissors from within outward through the transverse incisions in the rectal wall, the diseased rectum above is separated all around on its outer surface from the surrounding tissues and drawn down. The vessels are tied as they are cut, but if the dissection is made mostly by tearing with the fingers the greater part of the hemorrhage can be arrested by pressure. A temporary suture with the ends left long is then passed through the anterior and posterior walls of the rectum above to prevent its retraction, while the diseased part is excised by a transverse division

of the bowel in the healthy tissue below the retention sutures.

The cut ends of the rectum are united all around by interrupted sutures passed with a sharply curved needle, and then the incisions in its anterior and posterior walls. A large drainage tube surrounded by light packing and reaching above the point of division is placed in the rectum, the wounds in the perineum and behind, including the sphincter, are closed with deep sutures and a drainage tube placed in the lower angle of each.

C. *Hueter's Operation by a Perineal Flap.* (Fig. 237.) The patient occupies the lithotomy position and a sound is introduced into the urethra. A flap, including the anus and adjoining part of the perineum, is marked out of an inverted U-shape, having the anus a little in front of the centre of the base, which is posterior. To form this an

FIG. 237.



Remotion of the rectum, showing Hueter's curved incision. The straight incision is that for posterior rectotomy.

incision is made through the skin and subcutaneous tissue, starting at the level of the posterior end of the tuber ischii outside of the outer border of the sphincter ani, passing forward and crossing the perineum close to the posterior insertion of the scrotum, then backward to terminate on the other side of the anus outside the sphincter opposite the starting point. The incision is deepened, and anteriorly

in the bend of the U, the junction of the accelerator urinae with the compressor urethrae muscles cut through, and the flap including the sphincter ani turned down.

Working in from in front the rectum is isolated on all sides and the diseased portion excised by transverse division of the bowel through healthy tissue above and below the disease. The bleeding in this large wound is stopped by ligation or pressure.

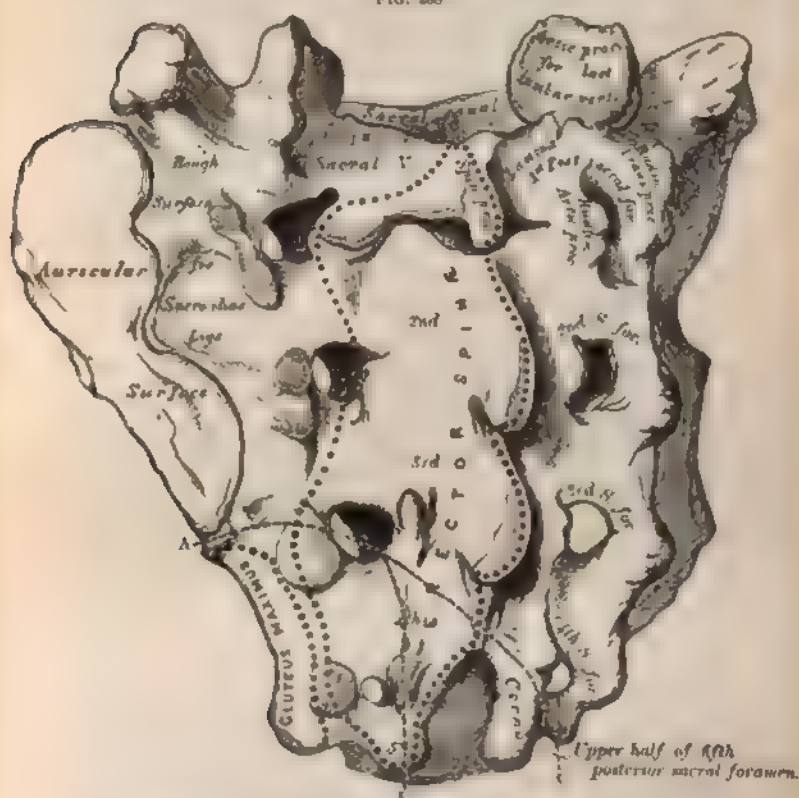
The cut ends of the rectum are brought together all around with sutures, and the flap replaced, with a drain and light packing in each lower angle. A tube and packing reaching above the line of division is then inserted through the anus. The mucous membrane might first be united by a separate row of sutures not entering the muscular coat, which is afterward brought together by sutures of catgut penetrating the muscular coat alone, so as to bring the suture line in the mucosa below that in the muscularis and thus make communication less easy for the feces from the interior of the bowel to the perirectal tissue. Zuckerkandl's method for reaching the seminal vesicles (q. v.) is very similar to this operation.

D. *Resection of the Rectum from behind* (Kraske's Operation) *with Removal of the Coccyx and part of the Sacrum*¹ The patient is placed on the right side and an incision is made in the median line from the middle of the sacrum to the anus and carried down to the bone. The fibres of the gluteus are detached from the lower part of the left half of the sacrum and from the coccyx, and the latter bone removed. The left side of the incision is then drawn forcibly aside and the greater and lesser sacrosacral ligaments successively divided close to their attachment to the sacrum. This gives access to a large portion of the rectum, but if more room is desired it can be obtained by chiselling away the lower left part of the sacrum below the third sacral foramen and including the fourth without opening the sacral canal. The anterior branches of the fourth and fifth sacral nerves are necessarily divided in this procedure.

¹ Arch. f. klin. Chir. 1886, vol. xxxii, p. 266. For a review of this operation and its modifications, see Frank. Wien. klin. Woch., 1891, vol. iv, p. 900.

The posterior branches and the fifth nerve are of no importance, but the nerve-supply of the levator ani, coccygeus, and sphincter ani on the left side is of course cut off.

FIG. 238



Resection of the rectum from behind

A, B. Portion of the sacrum removed in Krücke's operation

A, C. Hochenegg's modification.

Hochenegg's modification of the bone removal is represented in Fig. 238.

Bardenheuer still further modified it by the removal of all the sacrum below the third sacral canal, which destroys

the possibility of subsequent restoration of the function of the sphincter.

The rectum is now freed by division of the connective tissue binding it to the sacrum, and drawn downward so far as may be necessary to bring the subsequently cut ends of the gut into apposition without undue tension on the sutures. To give more room and greater protection to the important male organs lying close in front of the rectum, the sphincter and rectal wall from the anus up to the tumor can be cut posteriorly in the median line; but it is not always necessary.

The growth is then freed by the finger and blunt-pointed scissors from its lateral and anterior connections and excised with a margin of healthy tissue, by transverse division of the rectum above and below.

If the relations of the tumor make it necessary, the peritoneal cavity must be opened and involved portions of the peritoneum, together with any glands which can be felt, removed with the tumor. The peritoneum is then drawn together with fine catgut sutures and secured against infection by an iodoform-gauze packing. The anterior half of the divided bowel is united by silk sutures through its mucous and muscular coats, while the posterior half is left open and, if possible, sutured to the skin at the margins of the wound; it can afterward be closed by a secondary operation.

If the anus and adjacent rectal wall have been split posteriorly, the rectal part of the wound is closed by interrupted catgut sutures and the sphincter drawn together by deep silk or silver-wire sutures passed in the manner described for restoring a completely ruptured perineum.

The overlying parts and the upper and lower angles of the posterior wound are drawn together with silk sutures, and a drainage tube and packing placed in each angle. The centre of the wound, with the open half of the rectum, is packed and a drainage tube passed into the bowel above. Afterward the patient will have to be kept on a water-bed.

A colotomy performed a week or two before this operation is of great assistance in keeping the wound aseptic and avoiding the very frequent and early dressings otherwise necessary.

Heineke recommends an L-shaped incision from the anus to the coccyx, then along the left border of the sacrum up to the fourth sacral foramen, and then transversely to the right border of the sacrum. The bone is chiselled through in this line and the soft part of the flap turned down and to the right. Rydygier dispenses with the transverse incision in the skin.

Levy divides the sacrum transversely a finger's breadth above its lower extremity, and from each end of the transverse incision carries one downward toward the ischial tuberosities, the soft parts attached to the side of the sacrum below its point of transverse division are cut, and the bone-and-skin flap turned down.

Hegar employs a V-shaped incision starting at the posterior inferior spines of the ilia and following the sides of the sacrum to the tip of the coccyx. The periosteum is separated from the anterior surface of these bones; the sacrum sawed transversely and turned up.

Almost any of these methods of operation gives access to the female pelvic organs.

LIVER.

Anatomy. The level of the upper surface of the liver is indicated by a line drawn through the fifth chondro-sternal articulation on the right side and through the sixth on the left. It is uncovered by the ribs where it crosses the sub-costal angle, from the ninth right to the eighth left costal cartilage. The left lobe extends one and a half to two inches beyond the left margin of the sternum. The lung descends over the upper surface of the diaphragm and liver on the right side to the lower border of the sixth rib in the mammary line, in the mid-axillary line to the upper border of the eighth rib, and in the scapular line to the upper border of the tenth rib. The pleura descends about half an inch lower, following the costo-chondral junction, or the bony extremities of the ribs, and the lower border of the eleventh rib. As the twelfth rib is sometimes very short, it may be overlooked. Therefore the ribs should be counted, and the lower edge of the pleura will be found

passing horizontally from the lower border of the twelfth dorsal vertebra to the lower border of the eleventh rib.

The gall-bladder is about four inches long and an inch wide, and normally holds about an ounce. Its fundus touches the abdominal wall immediately below the ninth costal cartilage near the outer border of the right rectus muscle. The cystic duct is about an inch long, and the common duct three inches long. The latter descends in the right border of the lesser omentum behind the first portion of the duodenum, in front of the portal vein and to the right of the hepatic artery; it then passes between the pancreas and duodenum, behind the pancreaticoduodenalis artery, to empty into the middle of the inner side of the second portion of the duodenum.

Abscess of the Liver. An incision, preferably longitudinal, three or four inches long is made over the most prominent part of the tumor below the ribs. The incision is deepened to the peritoneum, and if the liver is found adherent beneath this incision the abscess is simply incised for about an inch and drained with a large tube, and packing if necessary, bearing in mind the very friable character of the abscess-walls. If the liver is not adherent where the abdomen has been opened, but is found to be so at some other spot below the ribs, another incision is made through the parietes over this spot, and the abscess reached through the safely adherent area. The first incision, having served as a guide, is closed in the usual way and well protected from infection before the abscess is opened.

If the abscess must be opened immediately, and there are no adhesions to the parietal peritoneum, a sponge packing is inserted to protect the rest of the abdominal cavity, and the point of an exploring-needle buried in the liver. The piston is immediately withdrawn and the needle slowly pushed on in a straight line. By withdrawing the piston as soon as possible pus will flow into the cylinder when it is first reached, and by pushing the needle always in a straight line unnecessary and easily-inflicted damage to the gland is avoided. If the first exploration fail, the needle must be taken out and reinserted in different straight directions till pus is found.

With the needle as a guide, a knife is then passed through the liver-substance into the abscess-cavity, while the liver is kept in as close contact with the abdominal wall as possible, rolling the patient on one side if necessary. The index-finger is quickly passed along the track of the knife and the opening enlarged to an inch or more and hooked up without force into the abdominal wound. Hemorrhage is controlled by packing. After the pus has been evacuated, the interior of the abscess-cavity is irrigated with warm boiled water; its opening is then plugged with a sponge, and the parietal peritoneum and the skin around the margins of the abdominal wound are united with catgut. After removal of the protective packing from the abdomen the liver is fastened in the wound by interrupted catgut or fine silk sutures passed through its substance at a little distance outside of the abscess-opening, to shut off its communication with the general peritoneum.

If the stitches show a tendency to tear out, sterilized gauze must be packed around the opening in the liver and the ends brought out of the abdominal wound.

The sponge plug is then removed and a large drainage tube inserted. Immediately before incising the liver an attempt can be made to closely unite the parietal and visceral peritoneum with catgut sutures around the proposed area of the incision. But the stitches may tear out or puncture and cause leakage from the abscess into the general peritoneal cavity. As the liver ascends and descends with respiration it cannot be fastened to the abdominal wall at a less distance than half an inch from the free border of the ribs and costal cartilages.

Whenever there is time it is always best to secure firm adhesions of the liver to the parietes in the selected region before evacuating the pus. A longitudinal incision two or three inches long is carried down layer by layer and the peritoneum opened and the liver exposed. After carefully protecting the surrounding viscera with sponge, the presence of pus is verified with a fine aspirating needle, and the point of puncture is then covered with an iodoform-gauze packing large enough to hold the margins of the abdominal wound apart and in contact with the liver. In addition, the parietal peritoneum and skin can be united

with catgut around the margins of the incision. If omentum should happen to intervene between the liver and parietes it must be pushed aside. A fairly tight antiseptic dressing is applied, and in the course of two or three days adhesions will have shut off the abdominal cavity and the abscess can be safely opened without an anæsthetic.

As before remarked, some surgeons supplement the packing placed on the exposed surface of the liver to cause its adhesion to the abdominal wall by sutures of catgut or fine silk passed with a curved needle deeply through the substance of the liver and fastened in the margins of the abdominal incision. But they are unnecessary and dangerous from possible leakage of the abscess alongside the sutures.

It is generally unwise to approach an abscess of the liver through the thoracic cavity; but if unavoidable, the selected intercostal space should be enlarged by resection of a rib, and the layers of the parietal and diaphragmatic pleura carefully united with catgut sutures around the proposed line of drainage. The surface of the liver is then exposed by an incision through the diaphragm and the future drainage track packed with iodoform gauze till adhesions have formed.

If the liver and diaphragm are already adherent, the abscess can be opened immediately, provided the pleural cavity is secured from infection.

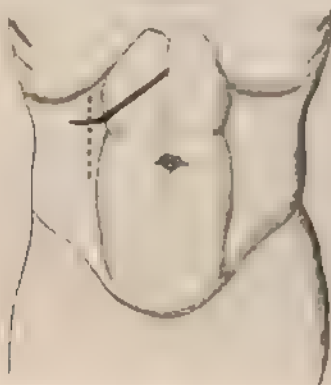
It is unsafe to aspirate a possible abscess of the liver through the unopened abdominal or thoracic wall.

HYDATID CYST OF THE LIVER.

The operative treatment of hydatid cyst of the liver is almost identical with that of abscess. After partial evacuation of its contents by a trocar and canula or aspirating needle the cyst wall can be more readily drawn into the abdominal wound and sutured there, and thus the rest of the abdominal cavity is more effectually protected than in the case of an abscess, and a cyst can be more safely opened immediately.

Cholecystostomy. (Fig. 239) An incision three or four inches long is made vertically downward from the lower border of the liver opposite the tip of the cartilage of the tenth rib (Fig. 239), and deepened layer by layer and the peritoneum opened. If an extensive dissection or an operation on the cystic or common duct is anticipated more room will be needed, and it is better to use an incision about four inches long, starting from the median line an inch below the ensiform process, extending obliquely downward and outward, and terminating horizontally (Fig. 239). If the liver is enlarged the oblique incision should follow a line

FIG. 239.



Incisions for exposing the gall-bladder

parallel to and just above its free border. When a distended gall-bladder is encountered it is carefully surrounded with a protective sponge packing and enough fluid drawn off with an aspirator to allow the walls thus relaxed to be pinched up on each side of the needle by the fingers or padded forceps and drawn into the abdominal wound. Sponges are wedged around it to prevent leakage into the peritoneum, and the fluid is evacuated by a trocar and canula, or a knife plunged into the bladder wall at the point of puncture made by the needle. In selecting this point of puncture allowance must be made for retraction of a distended bladder. If the bladder is not distended imme-

diately after opening the abdomen a finger is passed along its inner surface following the cystic and common duct, to explore for the trouble as far as the intestine. A careful dissection with the finger nail and blunt-pointed scissors may be necessary to separate adhesions to surrounding viscera and even to find the gall-bladder.

After protecting the rest of the abdominal cavity with a sponge packing the fundus of the bladder is drawn as far as possible into the abdominal wound and opened enough to admit one finger. All stones are then gently scooped or irrigated out, the abdominal wound partially closed in the usual way, and the protective sponges removed. The gall-bladder is fastened in the opened part of the wound by a continuous silk suture passed through the skin, peritoneum, and the whole thickness of the bladder wall around the margin of the opening in it. The suture line must be far enough away from the free border of the ribs to allow for the respiratory movements of the liver. Some operators precede the continuous suture through all coats of the bladder with interrupted sutures uniting its serous coat to the parietal peritoneum; but this is unnecessary.

A large rubber drainage tube is passed into the fistulous opening and an abundant absorbent dressing applied which will need frequent renewal. It is not advisable to close a wound of the gall bladder by the Czerny-Lembert method of suture and leave no communication with the abdominal incision.

Operations Involving the Cystic or Common Bile Duct. (Fig. 229.) The oblique incision is used, or the vertical changed later if necessary into a crucial or J-shaped incision. After locating the stone by the exploring finger and protecting the rest of the abdomen by a sponge packing, an attempt is made to manipulate the calculus back into the bladder or forward into the intestine, but with the recollection that the ducts are easily lacerated and very slightly distensible.

If it seem feasible to reach the stone from the interior of the gall-bladder, this viscus is opened in the manner already described, and one of the specially devised cholelithotomy forceps used to clip or nibble the stone into fragments,

guided by the other hand in the abdomen. The operation is completed as described for cholecystostomy. On the same principle an impacted calculus has been crushed by padded forceps applied to the exterior of the duct, and has been broken by the point of an aspirating needle puncturing the duct. Dr. McBurney extracted one after splitting the distal portion of the duct through an opening made in the duodenum for the purpose. For a stone otherwise irremovable from the cystic duct cholecystectomy is preferable to needling or crushing externally with padded forceps. But there must be no doubt about the patency of the common duct.

For a calculus impacted below the cystic duct, the oblique abdominal incision is used and the surrounding viscera are well protected and retracted by a sponge packing. The duct is opened in its long axis over the stone sufficiently to extract the latter, and the opening then closed by interrupted Czerny-Lembert sutures, which is more possible than it sounds, owing to the generally increased thickness of the duct wall from the irritation caused by the presence of the calculus. A drainage tube and iodoform gauze packing is carried from the abdominal wound down to the neighborhood of the suture line and the abdominal wound partially closed in the usual way.

If an opened gall bladder must be sutured in the abdominal wound at the same time, its opening must be separated as far as possible from the drainage tube by intermediate suturing.

CHOLECYSTENTEROSTOMY.

This term is used to designate the establishment of a permanent fistulous communication between the gall bladder and the intestine. The operation is designed to create a route by which the bile can pass into the intestine when the common duct is permanently obstructed, and when both the cystic and hepatic ducts are patent and communicate, and for some cases of persistent biliary fistula. The abdomen is opened, preferably by the vertical incision, and a convenient loop of intestine as near the duodenum as possible is isolated by iodoform-gauze bands tied around the

gut above and below, and to this isolated loop the gall-bladder is sutured and the communication established in the same manner as described for intestinal anastomosis.

The bladder is first emptied by an aspirating needle entered as near as possible to the site of the future fistula. A continuous fine silk suture is passed uniting the serous coats of the bladder and the intestine at the convex free border of the latter for a distance of about an inch and a half, and in front of this, as the parts lie exposed, a row of Lambert sutures is inserted. After carefully protecting the surrounding parts by a fresh sponge packing, the opposing surfaces of the gall-bladder and intestine are opened longitudinally for about an inch close in front of the Lambert sutures, and the interior of each irrigated clean. The mucous membranes are united by a continuous fine silk or catgut suture, and a row of Lambert sutures continuous with those already in place completes the serous apposition all around. The gauze, constricting bands, and sponges are removed and an iodoform-gauze packing placed around the suture line and the ends brought out of the abdominal wound, which is partially closed in the usual way.

Murphy, of Chicago,¹ has invented a mechanical contrivance called an "anastomosis button" for establishing a fistula between any of the hollow viscera without the employment of sutures. It consists of two buttons which slide on a hollow cylinder, so arranged with a spring that the opposed margins of their concave surfaces are kept in contact and cause a pressure-necrosis of the visceral walls in their grasp, thus making a hole in the diameter of the button, which is later passed in the feces.

However it may be criticised for other purposes, it seems a peculiarly valuable contrivance for performing cholecyst-enterostomy. The button can be made small enough to be easily passed off by the intestine, and at the same time leave a communication with the gall-bladder large enough to be useful in spite of any probable subsequent cicatricial contraction.

The abdomen is opened by the vertical incision, the bladder is aspirated, and a selected loop of intestine isolated as

¹ New York Med. Rec., Dec. 10, 1892.

usual, and a protective sponge packing placed in the abdomen. A "purse-string" suture of fine silk is passed through the serous coat of the bladder and intestine enclosing an area on each large enough to contain a slit the length of the diameter of the buttons. The buttons are inserted in the longitudinal slits then made in the bladder and gut, and the wounds are drawn tight around the central cylinder by tying the sutures. The buttons are simply pressed together, and the wounds, with the suture in each, are shut within the concavity bounded by the margins of the buttons holding the serous surfaces in apposition.

The calculi are not disturbed, but left to be defecated with the button, and the abdominal wound is closed without drainage after removing the sponges.

CHOLECYSTECTOMY.

The abdomen is opened by the oblique incision and the gall-bladder surrounded with sponges. Starting at the fundus, an incision is made on each side of the bladder through the peritoneum at a little distance from the liver, and the bladder dissected out with blunt-pointed scissors as far as the cystic duct. The latter is divided between a double ligature of silk and the peritoneal flaps closed over the liver by a continuous catgut suture. The abdominal wound is partially closed around a tube, and light iodoform-gauze packing carried down to the former site of the gall-bladder.

SPLEEN.

Anatomy. The pedicle of the spleen will be formed by the gastro-splenic omentum passing from the hilum to the stomach and, continuous with this above, the suspensory ligament passing to the diaphragm. The splenic artery lies above the vein behind the upper border of the pancreas. The gastro-splenic omentum contains its terminal five or six branches which arise at a variable distance from the spleen and may enter its hilum over a considerable area. Most of the vasa brevia arise from these and turn

backward to the stomach, and near the termination of the main splenic artery the gastro-epiploica sinistra is given off. The venous branches correspond to the arterial.

SPLENECTOMY.

A vertical incision three or four inches long is made along the outer border of the left rectus muscle above the umbilicus, and the peritoneum opened. If the spleen has prolapsed into an already existing wound, the latter is simply enlarged as much as necessary. Adhesions are separated or divided between double catgut ligatures, and the tumor, which must be very gently handled, is fully exposed. After surrounding it with a sponge packing it is turned out of the abdominal wound, generally the lower end first. The abdominal opening should be made large enough to allow the tumor to pass without force, and the margins of the wound should be held back to avoid all traction on the pedicle. Starting at its lower edge, successive pairs of artery clamps are applied to the pedicle in advance of the line of division which is then made between them.

The spleen is then removed and the vessels in the grasp of each clamp are ligated separately with silk. As each clamp is removed bleeding points are sought for and secured; after this Greig Smith advises that the whole pedicle be surrounded by a ligature drawn moderately tight to lessen the arterial pressure distal to it on the ligatures of each vessel. The abdominal wound is then closed tight in the usual way.

KIDNEY.

Anatomy. The kidney lies imbedded in fatty tissue which is more abundant behind than in front, and from which it can be easily enucleated. Posteriorly the upper half rests against the diaphragm and the lower half upon the transversalis aponeurosis, and is crossed posteriorly by the last dorsal, the ilio-hypogastric, and ilio-inguinal nerves. In front, from above downward, the liver, duodenum, and

hepatic flexure of the colon are in contact with the right kidney; the stomach with the spleen externally, the pancreas, and descending colon are in relation with the anterior surface of the left kidney.

Thus the colon generally lies vertically in front of a renal growth on the right side, and on the left side crosses it obliquely from above downward and outward. The peritoneum over such a tumor can be divided on the outer side of the colon, but not on the inner, without interfering with the blood-supply of the bowel.

The renal artery, which may divide into one or more branches before entering the hilum, subdivides into terminal branches, which are said commonly to lie in front of the veins. The renal vein subdivides earlier than the artery, and the left vein receives the left spermatic and left inferior phrenic veins which are within reach of injury during treatment of the renal pedicle. The vessels lie in front of the ureter, which terminates near the lower border of the kidney in its pelvis. The latter subdivides in the hilum into two or three short trunks (*infundibula*), which in turn subdivide into the calices opening over the papillæ; so that a finger cannot pass from the pelvis into the first subdivision and much less into the second or calices.

As the twelfth rib may be rudimentary or absent the ribs should always be counted before a lumbar operation, in order to avoid the pleura, which is generally found to pass horizontally from the lower border of the twelfth dorsal vertebra to the lower border of the eleventh rib.

EXPOSURE OF THE KIDNEY.

Lumbar Methods. The patient lies upon the sound side with a sand-bag under the loin to widen the opposite exposed costo-iliac space.

A. *The longitudinal incision* is made along the outer border of the muscular mass formed by the erector spinae and sacro-lumbalis, which is about two and a half to three inches from the vertebral spines, and it should extend through the skin from the eleventh rib to the iliac crest.

(Fig. 240.) It is deepened through the middle layer of the lumbar fascia or the aponeurosis of the transversalis, and the posterior surface of the quadratus lumborum is exposed. The outer border of the muscle is cleared and drawn toward the spine, and after retraction of the sides of the wound, the peri-renal fat can usually be seen through the thin anterior layer of the lumbar fascia, moving synchronously with respiration. Space can be advantageously gained by dividing the outer portion of the quadratus close to its attachment to the ilium.

FIG. 240



Incisions for exposing the kidney. L. Longitudinal or vertical incision.
T Transverse incision. K. König's incision

On division of the thin intervening fascia the fatty capsule of the kidney is reached, and by tearing through it and stripping it toward the sides the posterior surface of the middle and lower portions of the kidney and its pelvis are exposed to sight and touch. At the outer border of the quadratus muscle the last dorsal, the ilio-hypogastric, and ilio-inguinal nerves will be encountered, and one or all may be divided if they cannot be sufficiently retracted.

Some additional space can be gained by drawing the last rib forcibly upward with a blunt hook, which is safer than

resection of a portion of the twelfth and even the eleventh rib, as has been done in a few cases. If the pleural or peritoneal cavity is accidentally opened, the rent should be immediately closed with fine catgut sutures and protected by an iodoform-gauze packing.

Except in persons who are very fat, this incision gives ample room for exploration, nephropexy, nephrotomy, and even for nephrectomy when the kidney is not very much enlarged.

B. *The transverse incision* (Fig. 240, T) is begun just within the outer margin of the sacro-lumbalis, a little below the twelfth rib, and carried outward parallel to the rib for about four inches. The muscular and aponeurotic layers are successively divided after recognition, until the retro-peritoneal layer is reached, and the kidney exposed by division of its fatty capsule, as in the preceding description. Additional space can be gained by a short longitudinal cut at the inner (vertebral) end of the main incision.

This incision is advantageous in nephrectomy when the kidney is much enlarged, and whenever it may be necessary to insert a hand into the peritoneal cavity.

C. *The combined longitudinal and transverse incision* consists of the longitudinal incision joined at any part by the transverse.

D. *König's incision*¹ (Fig. 240, K). Starting from the last rib, the incision passes vertically downward along the outer border of the sacro-lumbalis and erector spinae, curves forward just above the highest part of the iliac crest, and passes horizontally toward the umbilicus to end at the outer border of the right rectus. The vertical part of the incision is deepened first and carried down layer by layer until the peritoneum is reached in front of the anterior layer of the lumbar fascia. After the fingers are placed in the lower angle of this wound to protect the peritoneum beneath the horizontal part, the latter is deepened through the successive muscular layers until the peritoneum is exposed. It

¹ *Centralbl. f. Chir.*, 1886, No. 35, p. 597.

may often be advisable to make the vertical part of the incision run obliquely into the horizontal in the form of a flattened curve. This incision affords very free access to the kidney and a good part of the ureter, and the size of the wound does not materially add to the risks, but rather lessens them by the increased facility afforded for dealing with the pedicle or any complications.

At the close of the operation the divided muscles in the horizontal and curved parts of the incision are united by deep sutures and heal readily, while the vertical part can be packed and drained if necessary. In any ordinary case the horizontal part of this incision need not be extended beyond the vertical prolongation of the anterior axillary line.

Nephrotomy. The kidney is exposed by the longitudinal lumbar incision, and if the abscess or cyst which has made the operation necessary is perfectly apparent it only remains to cut into the most prominent part of the diseased tissue with the knife or thermo-cautery. But if there is any doubt about the presence or location of the disease it must be sought by an aspirating needle passed through the convex border of the kidney and its track followed by a knife. A finger then plugs and enlarges this incision while, if necessary, an assistant makes counter-pressure through the anterior abdominal wall to lift the kidney into the incision; then if the cavity is very irregular, or if there are separate pouches, the septa should be freely broken down to secure efficient drainage, and the interior of the cavity thoroughly scraped with a sharp spoon if its condition requires it.

Occasionally it will be possible and desirable to draw the edges of the sac into the parietal wound and stitch them to the skin or deeper tissues. Rubber tubes packed around with iodoform gauze are passed into all parts of the abscess cavity for drainage, and into any spaces in the cellular tissue about the kidney which may have been opened up and infected.

The extremities of the external wound are drawn together with silk, and a large absorbent dressing applied.

Nephrolithotomy. After the kidney has been exposed, preferably by König's incision, which also gives access to the upper part of the ureter, the surgeon proceeds to seek for signs of the presence and location of a calculus; the horizontal part of this incision should not be made at first of the full length, but later it is prolonged if found necessary.

The posterior surface of the gland is freed and the kidney palpated between the thumb and finger and any click or spot of especial density noted.

A fine needle is then passed systematically through the cortex or wall of the pelvis at intervals of half an inch, and not deeper than two and a half inches in a normal adult kidney, in order to avoid possible injury to the main vessels. Should this fail to detect the stone, some authors recommend that the finger should be introduced through an incision in the cortex and thus a thorough digital examination be made of the interior of the pelvis and calices.

If no stone is found the wound is closed with catgut sutures passed through the substance of the kidney, and the external wound is brought together around a drainage tube placed in contact with the renal wound. But unless the operator feels very sure of his diagnosis this method of exploration should not be carried out.

When a stone is felt by the needle, an incision is made with the knife or thermo-cautery through the cortex longitudinally or in a line radiating from the pelvis to the convex border. Unless it is very manifestly better to open the pelvis directly, an incision through the cortex is preferable to one through the walls of the pelvis on account of the less danger of a urinary fistula and troublesome hemorrhage. The latter can be readily checked by the pressure of the finger or by a catgut suture passed deeply through the renal substance.

Through the opening thus made the stone is picked or scooped out. If it is large or branched it may have to be crushed with a lithotrite or strong sequestrum forceps; septa should be divided with blunt-pointed scissors; occasionally stones have been encountered so large, or so numerous and difficult of removal, that nephrectomy has

been considered wiser than nephrolithotomy. After removal of the stone the orifice of the ureter is sought and that canal explored to determine whether it is free or whether plugged by a stone or mass of fibrin. If such an obstruction is found it may be pushed back into the kidney, or washed out by a stream of water directed into the distended ureter through the renal wound, or perhaps pushed downward into the bladder.

The stone or stones having been extracted from the kidney, the wound in its substance or in the pelvic wall is closed with catgut sutures unless there is so much suppuration present that every facility must be given for the escape of pus. Sometimes the gland will have become a mere abscess cavity containing the stone. Rubber tubes and iodoform-gauze packing are placed in contact with the kidney wound or in its interior, as its condition may require, and in the space possibly opened up behind it. A strip of gauze is carried down to the peritoneum beneath the curved part of the external wound, if König's incision has been used, and the wound closed with silk sutures up to the space where the drainage emerges.

Lumbar Nephrectomy. The kidney is exposed by König's incision, but, if there is any doubt about its removal, it should first be explored by the longitudinal incision, and afterward a transverse incision of the necessary length can be added at any convenient part of the longitudinal. The length of the transverse or horizontal part of König's incision is regulated by the size of the tumor. If inflammation has not materially changed the tissues immediately surrounding the kidney, it is comparatively easy, after reaching its posterior surface and tearing through the perirenal fat, to work the fingers in close contact with the capsule around the convex border and the two extremities and enucleate the kidney from its bed by separating all the attachments except the pedicle constituted by the renal vessels and the ureter.

In cases of long-continued suppuration where everything has become matted together, as, for instance, after nephrotomy for abscess, it may be easier to open the capsule and separate the kidney from its interior. The manipula-

tions must be gentle and without undue traction on the pedicle, and if abnormal vessels are encountered at the extremities of the gland they should be divided between double catgut ligatures. After isolation of the pedicle it may be tied off in sections by silk ligatures passed on a large full curved aneurism pedicle needle; occasionally the main artery can be recognized by sight or touch, and it is desirable that it, as well as the ureter, should receive a separate ligature whenever possible. If the pedicle cannot be isolated and brought into view or reached on account of the condition or situation of the adhesions, the entire pedicle can be tied *en masse*, preferably by the elastic ligature, which is drawn tight by the fingers in the depths of the wound and retained by a knot or stout clamp.

The part of the kidney substance distal to the ligature is then cut away, leaving enough margin to prevent slipping of the ligature, and the large stump which sometimes remains when the adhesions to the anterior surface have been very extensive is scraped as much as is safe and the elastic ligature is left to slough out. Occasionally the pedicle may be secured by a long, strong clamp till the kidney is excised and then the pedicle is tied by one or more ligatures on the proximal side of the clamp. If the ureter has been separately divided it is well to close it with a ligature, and if necessary to disinfect the stump or fix it in the external wound. The pedicle is finally again inspected to avoid any chance of hemorrhage, and then after the insertion of rubber drainage tubes and iodoform-gauze packing the external wound is partially closed.

During the course of a nephrectomy it may be necessary to enter the abdominal cavity; this can be done through the anterior extremity of König's or of the transverse incision; the surrounding peritoneal cavity is protected by the usual sponge packing, and after removal of the latter at the close of the operation an iodoform-gauze packing is inserted unless there is a certainty of asepsis, in which case the peritoneum can be again closed tight.

Abdominal Nephrectomy. The place of selection for the parietal incision is at the outer border of the rectus muscle, where it is sometimes called Langenbuch's incision. It

should not be less than four inches long, and should have its centre as nearly as possible opposite the centre of the tumor. The incision is sometimes made parallel to this, but further outward with the idea of making the operation wholly extra-peritoneal, and then it is only a modification of lumbar nephrectomy by the longitudinal incision. Sometimes the abdomen is opened in the median line. After division of the tissues in successive layers, including the peritoneum, the viscera are pushed aside and protected by flat sponges or brought out of the abdomen and wrapped in warm cloths.

The peritoneum over nearly the whole length of the enlarged kidney is then incised longitudinally on the outer side of the colon in order not to interfere with the blood-supply of the latter. This must always be done in this way unless the size of the tumor and the position of the colon make it impracticable. Occasionally it is possible, as shown by Halsted, to attach the edges of the divided peritoneum covering the kidney to those of the divided anterior parietal peritoneum, and thus entirely to shut off the general peritoneal cavity from the field of operation. By working with the fingers or blunt-pointed scissors the peritoneum is stripped from the anterior surface of the gland and the structures at the hilum exposed. All vessels, as they are encountered, are secured in advance whenever possible and divided between double ligatures. It may even be advantageous to go directly to the artery through a special incision in the peritoneum and tie it as the first step in the operation. The ureter is then isolated between two ligatures, and if extensively diseased it is brought out of the abdomen behind and fastened to the skin through the wound made in the loin for drainage; or if healthy the stump is simply disinfected and left.

During the removal of the kidney every effort must be made to avoid infection of the peritoneal cavity by its contents or those of the ureter. After this the gap in the posterior parietal peritoneum may be rapidly closed with a continuous catgut suture, and lumbar drainage provided for the space formerly occupied by the kidney by the insertion of a rubber tube and gauze, if necessary, through a small incision made in the loin. The abdominal wound is

closed in the usual way, with or without drainage, according to the necessities of the case.

The presence and condition of the other presumably sound kidney should always be ascertained as soon as the peritoneal cavity is opened in abdominal nephrectomy.

In cases of floating kidney in which the gland is fully pedunculated and invested by peritoneum, its removal will be conducted as in the case of any other pedunculated abdominal tumor, without stripping off the peritoneum.

Nephrorrhaphy or Nephropexy. This is the operation by which an abnormally movable kidney is permanently fixed in its proper position by suturing it to the abdominal wall.

The kidney is exposed by the longitudinal lumbar incision at the outer border of the sacro-lumbalis, and the fatty capsule divided longitudinally and stripped back from the surface of the kidney. Three or four stout catgut or silkworm-gut sutures are then passed with a curved needle from the anterior to the posterior surface, well within the convex border, at intervals of about half an inch, and then through the cut edge of the lumbar fascia in the inner lip of the wound, so that when tied they hold the kidney snugly up against the abdominal wall. The wound may then be closed for primary union, or packed with iodoform gauze to heal by granulation. Guyon sought to strengthen the cicatricial connection by removing a lung strip of the fibrous capsule; and Sulzer¹ recommends that the capsule be split and reflected so as to form a flap which can be stitched in the parietal wound.

URETER.

*Anatomy.*² The ureter lies behind the peritoneum on the psoas muscle and genito-crural nerve in the upper part of its course, and is crossed from within outward by the spermatic or ovarian vessels. As the ureters approach the pelvis they lie close to the spine between the psoas and the body of the vertebra, the right ureter being a little further out-

¹ Deut. Zeit. f. Chir. vol. xxxi.

² Cabot. American Journal of the Medical Sciences, 1882, vol. ciii. p. 13.

ward than the left, owing to the interposition of the inferior vena cava, with which it is in close relationship.

When the peritoneum in this region is stripped up from the parts beneath the ureter will always be found adhering to its under surface and on the left side, about half an inch to an inch outside of the point where the peritoneum becomes attached to the spine; on the right side the distance is slightly greater. The ureters cross the common or external iliac vessels to enter the pelvis, where they lie pretty closely over the lateral edges of the sacrum. They then run in the recto-vesical fold of peritoneum to enter the base of the bladder at a distance of two inches from each other and pass for a half to three-quarters of an inch between the mucous and muscular coats of the viscus before terminating. The vas deferens is between the ureter and the bladder. The narrowest part of the canal is close to the bladder, and this region, which is the most difficult of access, is also the one where a calculus is most likely to lodge. In the female the ureter for the last two, and in some cases three, inches of its course, lies in the broad ligament in close relationship with the cervix and vault of the vagina, and it can be reached by an incision in the vault extending outward and backward within the layers of the broad ligament.

*Operations on the Ureter.*¹ Almost the only indications for operations upon the ureter are found in wounds of it or in the necessity for the removal of an impacted calculus. The ureter should always be opened extra-peritoneally for the removal of a stone, inasmuch as the wound cannot be satisfactorily closed with sutures, and it has been proven that at least a longitudinal wound will in time, if there is proper drainage, spontaneously close and allow the urine to pass in its natural channel.

The ureter should generally first be explored through a median abdominal opening made below the umbilicus, and always thus explored if there is doubt about the location of the stone. In some instances it has thus been possible to manipulate the calculus up into the pelvis of the kidney or

¹ A summary of this subject with the bibliography will be found in the *Annals of Surgery* 1894, p. 257.

down into the bladder, and even when it was soft to break the stone into fragments with the fingers and then get them into the bladder.

If the ureter must be opened, an incision is made three or four inches long wherever necessary in a line drawn from a point on the anterior edge of the sacro-lumbalis a finger's breadth below the twelfth rib, parallel to the rib as far as its tip, thence downward toward the middle of Poupert's ligament till about opposite the anterior superior spine of the ilium. From this point the line again turns inward to end at the outer border of the rectus muscle.

The tissues are divided layer by layer till the peritoneum is reached, and then the latter membrane is gently raised by the fingers from the parts beneath till the ureter is exposed adhering to its under surface. In the middle third of the course of the ureter it will be found about half an inch to an inch from the spinal attachment of the peritoneum. The ureter is incised longitudinally over the stone sufficiently to extract the latter. In several instances this wound has then been closed by a continuous suture of fine silk through the outer wall of the ureter, but not penetrating its lumen, and with one end of the suture left within reach from the parietal opening to remove it in case of supuration. This may at any rate narrow the opening and so hasten its repair, though Calot¹ considers suturing a wound of the ureter unnecessary.

A rubber tube and iodoform-gauze packing is placed in contact with the ureteral wound for drainage of escaping urine, and the ends brought out of the external incision which is partially closed around them.

In some cases where the stone can be felt through the vault of the vagina, and it is between the layers of the broad ligament not more than an inch or an inch and a half from the bladder, an incision can be made in the vault outward and backward and the finger pushed up separating the intervening tissues in the broad ligament till the stone is reached. The ureter is then opened longitudinally on its under side and the stone picked out. This wound has been successfully closed with sutures, but it

¹ Loc. cit.

will generally be found sufficient to place a drainage tube and packing in contact with it and bring the ends out through the vagina.¹

In other cases if the stone has reached the bladder cavity and lies between the mucous and muscular coats, it should be attacked through the interior of the bladder, probably by a suprapubic cystotomy; but, if it is further off and the bladder wall must be opened to expose the stone, there is great danger of urinary infiltration in the surrounding parts, and Cabot's method, described below, should be used.

With these exceptions the lower third of the ureter must generally be approached from behind. An incision is made three or four inches long, starting just below the tip of the coccyx and following the lateral border of that bone and the sacrum on the side of the affected ureter. The sacro-sciatic ligaments are divided close to the sacrum and the coccyx excised, and if necessary the lower lateral border of the sacrum also, as in Kraske's operation.

With a large sound in the rectum to map it out and push it aside, the ureter is sought for close to the edge of the sacrum and opened longitudinally on its under side opposite the calculus sufficiently to extract the latter. The resulting wound is simply packed and drained.

Wounds of the Ureter. Extraperitoneal wounds of the ureter involving a part of its circumference should be treated as already described, i. e., by a counter-opening and drainage through the abdominal wall in a direction as nearly as possible directly backward. When the wound has been intraperitoneal or has involved the entire circumference of the ureter, the divided ends have been ligated with catgut and the stumps disinfected and covered with an iodoform-gauze packing, which was brought out of the abdomen, and the corresponding kidney has then been extirpated.

Or, after ligating and disinfecting the divided lower end of the ureter, the upper end has been brought out in the loin through a counter-opening made above the crest of the ilium behind, and a urinary fistula established, for the cure of which nephrectomy has been subsequently performed.

¹ Cabot. Loc. cit.

Some recent experiments on dogs¹ seem to prove that one ureter can be implanted in the rectum, or colon, without especial danger or subsequent inconvenience, and this fact might be of great service in case of an accidental division of one ureter during a pelvic operation.

There is also reason to believe that it may be possible to obtain reunion of the divided ureter and re-establishment of the flow of urine to the bladder by partial suturing of the divided ends after trimming them obliquely or into corresponding salient and re-entrant V's. If union can be thus obtained over a part of the wall, the remaining fistula may heal as after longitudinal or oblique wounds.

In several reported instances, when it has been divided near its lower end, the ureter has been implanted in the bladder above the point where it normally enters this viscus. The cut end of the ureter is slit up longitudinally for half an inch and its margins sutured with catgut to the edges of an opening in the bladder. Drainage must be provided for.

Kelly² has successfully employed on the human subject a method used by Van Hook in experiments on dogs, and has called the operation *uretero-ureterostomy*. Other similar cases are being reported. The divided extremity of the distal segment is tied off by a ligature and just below the latter the lumen of the distal segment is opened longitudinally sufficiently to permit the upper segment to be inserted into the lower. A couple of sutures in the cut edge of the proximal stump are threaded on needles and passed through the slit into the lumen of the lower stump and out through its walls just below the longitudinal opening and used to draw the upper into the lower portion of the tube. The ends of these sutures are tied, and one or two others inserted at the point where the stumps are in contact. Gauze is then packed around the suture line and brought out of the abdominal wound for drainage.

CASTRATION.

The usual preparations for an antiseptic operation are made, and a sterilized towel wet in a 1:1000 solution of

¹ *Annals Surgery*, 1892, vol. xvi. p. 193.

² *Annals Surgery*, 1894, p. 70.

bichloride of mercury is wrapped around the penis and pinned to the loose skin at its root. The scrotum on the affected side is grasped by the thumb and fingers of the left hand and drawn tight in such a way as to make the diseased testis and its cord prominent and tense. An incision is then made from the external abdominal ring along the entire length of the anterior portion of the scrotum; but if the skin is involved this incision should be made elliptical in the direction required to include the diseased area.

After division of the skin and dartos the testicle is slipped out of the wound, and the remainder of the dissection and isolation of the gland and cord is completed more by tearing with the fingers and blunt-pointed scissors than with the knife. The tunica vaginalis may be opened or not, and is removed with the testicle.

A part of the cord is selected well above the disease, and, if necessary, the inguinal canal is opened by division of the tissues over it in successive layers. A silk thread is passed through the cord to insure control of it, and then the latter is divided through the sound portion by repeated cuts of the knife and the vessels are caught and tied with catgut as they bleed. Hemorrhage from the scrotal wound must be completely checked by ligation or by torsion and pressure.

There should be three arteries in the stump, the spermatic, the artery of the vas, and the cremasteric. The ligatures are all cut short and the internal incision is closed by interrupted sutures of fine silk, taking care not to invert the edges of the scrotal portion. Drainage is unnecessary unless the wound has been exposed to infection, in which case a small rubber tube with lateral perforations is placed in its depths and brought out at the most dependent angle, while the surface is partially drawn together around an iodoform-gauze packing. Sometimes a healthy part of the cord cannot be reached and it must be tied through diseased tissue. It is then especially necessary to ligate each vessel separately, and an iodoform-gauze packing is placed in contact with the stump.

A dry dressing is applied with a hernia bandage, over which is placed a sheet of rubber tissue, perforated for the

penis, to prevent soiling by urine, and the whole retained by a flannel spica bandage.

HYDROCELE.

The operations for the relief of hydrocele are *palliative* or *radical*. The object of the former is simply to remove the liquid from the sac; that of the latter to prevent its reaccumulation by excising the sac, or by obliterating its cavity by exciting adhesive inflammation of its walls. Injection of the tincture of iodine is the means most commonly employed for the latter purpose. The position of the testicle within the sac should always be ascertained, in order that it may not be injured by the trocar. This is best accomplished in most cases by examining the sac by transmitted light, the testicle appearing as an opaque spot in the general translucency; its usual position is at the lower posterior portion of the sac.

Puncture of the Sac. After the adoption of every anti-septic precaution the tumor is grasped at its upper portion in such a manner as thoroughly to stretch the skin covering it, and a sterilized trocar is plunged into the centre of its anterior surface, supposing the testicle to occupy its usual position below and behind. The depth to which the trocar enters is regulated by the finger placed along its side, and the surgeon satisfies himself that the point is well within the sac by moving it freely in all directions. The canula should fit the trocar snugly in order that its anterior end may not push the tissues before it instead of penetrating them. If the intention is only to remove the liquid, the canula is withdrawn as soon as the flow has ceased, and the puncture closed with adhesive plaster or collodion; but if a radical cure is to be attempted, the tincture of iodine must first be thrown in. The French surgeons use the tincture diluted with two or three parts of water, and prevent precipitation by adding iodide of potassium to the mixture. They throw a considerable quantity into the sac, retain it there for three, four, or five minutes, and then withdraw it.

Van Buren and Keyes¹ recommend the "pure tincture thrown in gradually, retained several minutes, and worked around in such a way that every portion of the inner wall of the sac may come into contact with it;" the quantity of the tincture used should be equal to half the amount of liquid drawn off. Large hydroceles must first be reduced in size by one or two tapplings. The injection of fifteen to thirty minims of 95 per cent. carbolic acid has given good results.

Care must be taken that the injection is not thrown into the subcutaneous connective tissue, an accident that is very likely to be followed by sloughing of the scrotum; the surest way of avoiding this accident is to throw in the injection before the liquid has entirely ceased to flow out. If the accident does occur, free incisions must be made at once into the scrotum at the seat of the infiltration.

Radical Cure by Excision (Volkman). With every antiseptic precaution the sac is freely laid open by a longitudinal anterior incision and the cut edges of the skin and tunica vaginalis stitched together all around. The cavity is then lightly packed and allowed to heal by granulation, a process which requires a couple of weeks. If the surgeon is sure of the asepsis the packing may be withdrawn at the end of three days, and then, by applying firm pressure, the wound can be caused to heal much sooner.

VARICOCELE.

The treatment of varicocele may be palliative or radical. By the former, support is given to the testicle and the over-distended veins; by the latter, it is sought to obliterate the lumen of the veins at one or more points. There are several risks involved in the radical treatment, which, when taken in connection with the usual harmlessness of the affection and the efficacy of palliative measures, should make the surgeon slow to employ it. The risks are: Possible phlebitis, which may lead to pyæmia; possible atrophy of the testicle, in consequence of the obliteration of all the veins

¹ Genito-Urinary Diseases with syphilis. New York, 1926, p. 104.

or the inclusion of the artery in the ligature; and, finally, the likelihood of a return of the affection if all the veins are not obliterated. The palliative treatment consists in wearing a suspensory bandage, or in excising a large portion of the scrotum, with the expectation that what is left will act as a natural suspensory.

Excision of the Scrotum. A long clamp is required, between the blades of which a large fold of the scrotum is pinched up parallel to and including the raphé. This fold is then cut off about one-eighth of an inch from the outer side of the blades, and numerous interrupted sutures applied before the clamp is removed. If bleeding is feared, these sutures should be cut about a foot long, and not tied until after the clamp has been taken off and all bleeding points secured.

The radical treatment consists in obliterating the lumen of the veins by dividing them with the knife or the canter, excising a portion of their length, compressing and strangulating them by means of ligatures or clamps, or simply exposing them to the air. Of these excision is the only method to be commended.

Subcutaneous Ligature. A needle carrying a catgut or antiseptic silk ligature is passed through between the veins and the cord, reëntered at the point of emergence, passed around the other side of the veins close under the skin and brought out and tightly tied at the first point of entry. If this is very exactly done, so as not to include the deeper part of the skin at either puncture in the loop, and is treated antiseptically, it will usually heal without suppuration. Its execution is facilitated by making the punctures with a knife.

Open Method of Ligation. A fold of the scrotum over the enlarged veins above the globus major is pinched up and divided with scissors, making a longitudinal incision about an inch long. The thumb and forefinger of the left hand grasp the vas deferens, pushing it backward, while the veins at the same time are forced forward into the cutaneous wound. The veins are isolated by a slight

dissection with the knife or blunt-pointed scissors and a ligature of catgut or fine silk is passed under them by an aneurism needle. After another inspection to make certain the vas is not included, the ligature is tied tightly and the ends cut short. The small incision is then closed without drainage and closed anti-septically.

Some surgeons pass the ligature double, tying off a knuckle of vein, which is then excised and the divided ends brought into apposition by the long ends of the ligature, which are then cut short.

AMPUTATION OF THE PENIS.

Partial. The root of the penis is constricted by a piece of rubber tubing and the skin is slightly drawn back toward the pubes and divided by a circular sweep of the knife. With a sound in the urethra the corpora cavernosa are cut transversely at the level of the retracted skin down to the corpus spongiosum, which is then dissected out by a few strokes of the knife, and, after withdrawal of the sound, is cut transversely, including the urethra, about half an inch longer than the corpora cavernosa to allow for retraction of the urethra. The cut ends of the vessels in sight, including the two dorsal arteries and the arteries of the corpora cavernosa, which lie in the centre of these bodies, are tied with fine catgut, the tourniquet removed, and, after checking the hemorrhage by ligation or torsion, the cut edges of the urethra and skin are united with fine silk.

To prevent cicatricial contraction of the mouth of the urethra, the latter should be split longitudinally for about half an inch on its under surface before stitching it to the skin.

Complete. The patient is placed in the lithotomy position, a sound introduced into the bladder, and the scrotum is split from before backward along its raphé. The corpus spongiosum is dissected out as far as the triangular ligament, and divided about an inch in front of the latter after withdrawal of the sound.

A circular incision continuous with the anterior ex-

tremity of the scrotal incision is next made through the skin around the root of the penis; the suspensory ligament is divided, and by dragging on the penis and retracting the sides of the scrotal wound, the corpora cavernosa and their posterior prolongations, the crura, are removed from the rami of the pubes and ischium by the knife or periosteal elevator. All the attachments of the penis having thus been severed and the bleeding points tied, as they are encountered, with fine catgut, the urethra is split for half an inch on its floor and sutured to the edges of the wound well forward in the perineum, and the remainder of the wound is united between the testicles so as to form a separate scrotum for each of them.

When this extensive operation is undertaken for cancer of the penis the inguinal glands on both sides should be removed at the same time, whether perceptibly enlarged or not.

OPERATIONS FOR PHIMOSIS.

Dorsal Incision. A director is passed through the preputial orifice along the dorsum of the glans to the corona, a curved, sharp-pointed bistoury guided along it, the skin transfixes at the point of the director and divided straight down to the preputial orifice. Nothing more is absolutely required, for the wound left to itself will heal promptly; but it is well to round off the corners and to unite the edges of the mucous membrane and skin by fine sutures. This is a very satisfactory operation when the prepuce is not redundant, but if there is much excess of tissue the foreskin will present an awkward, lop-eared appearance for many years, and in such cases, therefore, circumcision is to be preferred.

This operation is often required in cases of sub-preputial chancroid, and then it becomes a matter of considerable importance to prevent inoculation of the wound by the chancroidal virus. A method introduced by Dr. J. H. Lowman into the venereal wards of Charity Hospital, New York, has proved very efficient in this respect. A solution of nitrate of silver, forty grains to the ounce, is injected under the prepuce, and followed by the injection of a saturated solution of common salt, to remove the excess of the caustic. The sore having been thus rendered temporarily

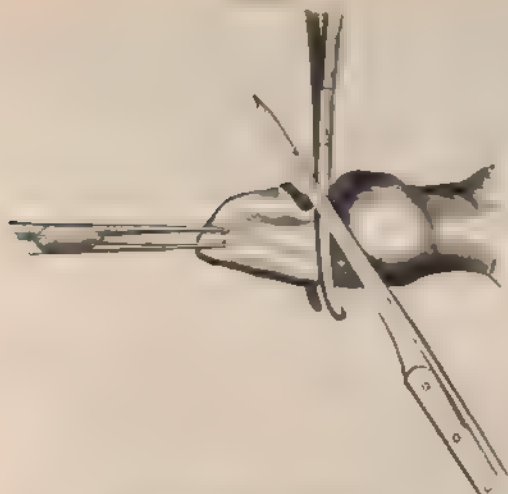
innocuous by the coagulation of its secretions, the incision is made and the sore cauterized with nitric acid.

Circumcision. A number of instruments have been invented and a great variety of methods proposed, which do not need to be repeated here, for the object they had in view, that of insuring division of the skin and mucous membrane of the prepuce at the same level, is not a matter of much importance, since any excess of the latter can be readily removed afterward. There is, however, one modification introduced by Dr. Keyes¹ which is of great importance, for it insures the removal of the constriction and protects the wound from being harmed by erections while healing. This modification consists in an additional longitudinal division of the skin for about half an inch along the dorsum of the penis, and sometimes, also, on the opposite side along the course of the urethra, after the end of the prepuce has been cut off (Fig. 242, A'). The corners left by these incisions are rounded off, and the effect is to increase the circumference by twice the length of the incision. As the stricture is sometimes due to insufficient breadth of the skin covering the glans, the value of this simple modification is evident.

Operation. A probe is first introduced and swept over the surface of the glans to break up any adhesions that may exist, and the edge of the preputial orifice is then caught at opposite points with the thumb and forefinger of each hand and drawn forward, care being taken to make the tension upon the less elastic mucous membrane, and not only upon the skin. While the prepuce is thus drawn forward, an assistant clasps a pair of long narrow-bladed forceps vertically upon it just in front of the apex of the glans, directing the blades forward as well as downward (the penis being horizontal) parallel to the general direction of the corona, and the glans should then be moved freely behind them to make sure that it is not caught between the blades. The portion of prepuce in front of the forceps is then cut away with scissors or a knife (Fig. 241) and the forceps taken off.

¹ Van Luten and Keyes: *Genito-Urinary Diseases, with Syphilis*, New York, 1874, p. 11.

FIG. 241.



Circumcision. First incision.

It will then be seen that the glans is still covered by a more or less tightly fitting sheath of mucous membrane, while the looser and more elastic skin retracts to or beyond the corona, leaving a belt of raw surface below (Fig. 242).

The mucous membrane is next divided with scissors along the dorsum back to the corona (Fig. 242, *BD*), and the skin divided in the same direction along the dorsum for a distance of half an inch from its cut edge (Fig. 242, *AC*), and also on the under side along the urethra, if considered necessary. The corners of these incisions are rounded off, and the edges of the mucous membrane and skin fastened together with numerous fine sutures, the first being placed exactly in the median line in front, the second at the frenum. If fine silk is used, and the sutures placed close to the edge, they may be left to cut their way out and come away in the dressings.

FIG. 242.



Circumcision. Raw surface left by retraction after first incision.

It is always difficult to get accurate adjustment of the edges at the ends of the longitudinal incisions on the dorsum, and usually a small triangular gap is left to fill by granulation. Dr. D. B. Delavan¹ proposes to meet this objection by leaving a triangular piece projecting in the centre of the dorsal portion of the cutaneous incision. Fig. 243 shows the line of incision, Fig. 244 the resulting triangles of skin and mucous membrane; the apex of the latter, *H*, which at first is drawn upward by its close connection

FIG. 243.



Circumcision. Delavan. First incision.

FIG. 244.



Circumcision. Delavan. Fitting in the triangle.

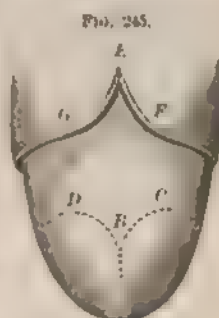
with the apex of the skin triangle, *A*, so that its mucous surface is outward, is represented in the figure as it appears after having been freed by dissection, if necessary, and turned down, leaving its raw surface out. The mucous membrane is then slit up to the corona at *D*, as usual, after cutting away its triangle, and the point *A* is stitched fast to *D*, *B* to *E*, *C* to *F*, and the remainder of the edge as usual.

The only objection to be made to this device is that it sacrifices the liberating longitudinal incision of the skin, and Dr. Keyes² has met this by taking the triangular flap from the mucous membrane instead of from the skin. He cuts off the prepuce by a straight incision, and divides the skin along the dorsum as before; and then, instead of splitting

¹ Oral communication, 1876.² Oral communication, 1876.

the mucous membrane in the same manner (Fig. 242, *BD*), he makes a Y-shaped incision (Fig. 245, *BDC'*), and removes the anterior strip of mucous membrane by continuing the incision from *C* and *D* around to the frenum. The point *DBC* is then reflected, fitted into the triangular gap *G E F* left by the longitudinal incision in the skin and the rounding of its corners, and the edges are united by sutures, as before.

If broad adhesions exist between the glans and prepuce, and it is feared that the raw surfaces left by their division will reunite, all the mucous membrane may be removed, except a ring about one-eighth of an inch wide adjoining the corona; the skin is then drawn forward, and united to the narrow ring of mucous membrane. The raw surface on the glans, having nothing to adhere to, cicatrizes naturally.



Circumcision. Keyes.

PARAPHIMOSIS.

A description of the methods of reduction by taxis or by compression of the engorged prepuce and gland does not lie within the proposed scope of this work, and the operation of division of the constricting band hardly needs to be described, for it consists simply in dividing the band from without inward at one or more points, until the constriction is sufficiently relieved to allow the prepuce to be drawn forward. It is well to make the first incision in the median dorsal line so as to profit by it afterward, if an operation for phimosis is considered necessary. If inflammatory adhesions have formed along the line of the constriction, forcible attempts to reduce the paraphimosis should not be made, but, after division of the band, the parts should simply be dressed with cold and soothing lotions.

DIVISION OF THE FRENUM.

Verneuil¹ employs the following method: He makes the frenum tense, transfixes it close to its attachment to the glans with a narrow bistoury or tenotome held with its side parallel to the surface of the penis, and cuts out backward, making a triangular flap nearly half an inch long, with its apex directed backward. The liberated glans is drawn forward, the flap disappears, and the edges of the wound, which assumes the shape of a lozenge, are united by sutures.

EPISPADIAS.

The deformity known as epispadias is characterized by fissure of the roof of the urethra. In its complete form it is associated with separation of the symphysis pubis, and often with exstrophy of the bladder, in which case its treatment is subordinate to that of the more important defect (*q. v.*). In its slightest degree it is confined to a fissure occupying the dorsal portion of the glans penis, and extending from the meatus to the corona (epispadias balanique). The existence of this form has been denied, but Verneuil² reports two cases, in neither of which did the malformation cause any disturbance of function. In the more important varieties the urethra lies above the corpora cavernosa instead of below them, and is open on the roof from its anterior extremity nearly to the bladder; the glans is fairly developed, and may be grooved more or less deeply along its dorsum, while the rest of the corpus spongiosum is represented by a thin layer of erectile tissue under the urethra. There is sometimes partial or complete incontinence of urine, and the operative indication is to supply a channel through which the urine can be conducted without dribbling to a urinal.

Nélaton's Method. The prepuce is drawn downward and forward by means of a ligature passed through it, and held in this position during the operation. An incision is then

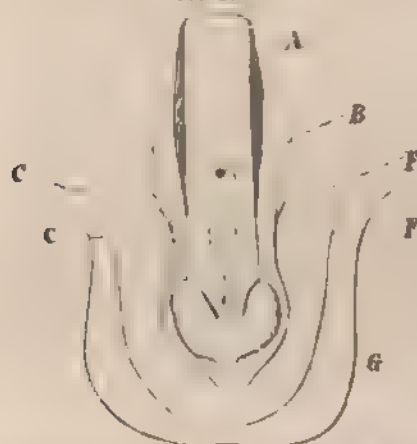
¹ *Chirurgie Ispadrice*, 1887, p. 731.

² *Loc. cit.*, p. 713.

made along each side of the urethral gutter at the junction of the skin and mucous membrane, beginning at the prepuce and ending at the abdominal wall. The external lip of each incision is dissected up for about one sixth of an inch, forming a flap on each side continuous with the skin; the inner lip of each incision is also slightly loosened. The flaps must be made as thick as possible.

A third flap is then marked out upon the abdominal wall, immediately above the urethral orifice leading to the bladder, by two vertical incisions united at their upper ends by a transverse one; it should be as broad as, and a

FIG. 246.



Epispadias. Nodden's operation. *A* Abdominal flap. *B* Urethral infundibulum. *C* *C'* Lateral incisions at junction of skin and mucous membrane. *F*, *F'* Scrotal incisions circumscribing *G*, the scrotal flap.

little longer than, the penis, dissected from above downward to its base, which corresponds to the interpubic ligament, and then reversed, its cutaneous surface inward, and its sides made fast by sutures to the inner lips of the incision on the penis, care being taken to make the contact as broad as possible. Demarquay¹ and Dolbeau² preferred to make the flap by prolonging the first two incisions up

¹ *Maladies Chirurgicales du Penis*, 1877, p. 623.

² *De l'Epispadias*, Paris, 1861. Plaque IV, Fig. 1.

the abdomen, thinking that the continuity of the incisions upon the abdomen and penis would increase the chances of success (Fig. 246, *C' C'*).

In order to give the abdominal flap greater thickness, and prevent its retraction during the process of cicatrization, Nélaton reinforced it by another taken from the scrotum. This scrotal flap is limited by concentric curved incisions (Fig. 246, *FF*), the upper one circumscribing the under half of the root of the penis in the peno-scrotal angle, the other at a distance below the first equal to the length of the penis, and is left adherent at both ends. After the flap has been dissected up, the penis is passed under it, bringing the raw surface of the reversed abdominal flap into contact with that of the scrotal flap, and the great circumference of the latter is fastened by three sutures to the outer lips of the two incisions made along the sides of the urethral gutter.

The canal thus formed is very large, and both Nélaton and Dolbeau found it necessary to diminish its size by applying the actual cautery to its interior. The operation devised by Thiersch is generally deemed superior.

*Thiersch's Method.*¹ This operation requires several months for its completion, since it is composed of four dis-

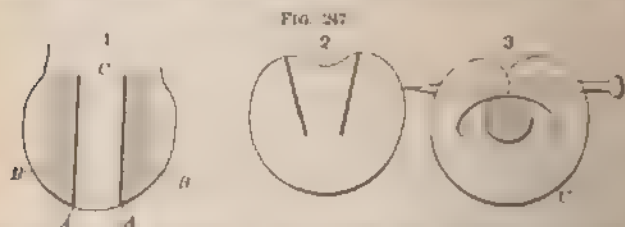


FIG. 247.
Epispadias. Thiersch's operation. 1 The penis seen from above. A, A The incision on each side of the gutter C. B, B The freshened surfaces. 2 Transverse section of penis showing the incisions. 3 The freshened surfaces brought together and closing in the urethra U.

ting operations performed at different times. In order to prevent the urine from coming into contact with the raw surfaces of the flaps Thiersch makes an opening into the

¹ Archiv für Hekkrankhe, 1899, pp. 20-36, and Langenbeck's Archiv, vol. xv Part II p. 379.

urethra through the perineum and maintains it during the entire period of treatment.

First Step (Fig. 247). Creation of the meatus and the portion of the canal occupying the glans. The surgeon makes a deep incision along each side of the urethral groove in the glans, pares the surface of the outer lip of each incision, brings the freshened surfaces into contact, and fixes them with two or three points of twisted suture.

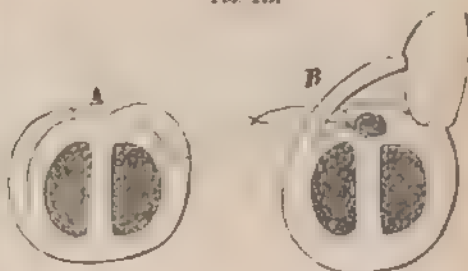
Second Step (Figs. 248, 249). Creation of the urethra along the body of the penis. The surgeon makes an incision through the skin and subcutaneous tissue at the edge

FIG. 248.



Epispadias. Thiersch. Second step. Incisions marking the two lateral flaps.

FIG. 249.



Epispadias. Thiersch. Transverse section of penis showing flaps.

of the urethral gutter on the right side, makes a short transverse cut outward from each end, and dissects up the rectangular flap thus marked out. On the left side he makes a longitudinal incision one centimetre external to the edge of the gutter, and a transverse incision from each end. This flap is dissected up, making it as thick as possible, and turned over so as to form a roof for the urethral gutter, its cutaneous surface directed downward, its raw surface upward. Several ligatures are passed through it near its free border and then through the base of the right-

hand flap, and the latter drawn across the former so that their raw surfaces are brought into contact throughout. The free edge of the right flap is then fastened to the skin forming the outer edge of the incision on the left side.

Third Step. To close the gap remaining between these two new portions of the urethra. A transverse incision is made in the prepuce, the glans passed through it, the borders of the gap pared and fastened to the edges of the incision in the prepuce.

Fourth Step. To close the posterior portion of the canal or infundibulum. The method employed is similar to that used in the second step of the operation, the flaps being taken from the groins. The left flap has the form of an isosceles triangle, and its base occupies the left half of the upper semi-circumference of the opening; it is turned over so that its cutaneous surface is directed downward, and its free border is united to the freshened posterior edge of the roof of the new urethra. The other flap is quadrilateral, its base corresponds to the right inguinal ring, and it is drawn over the first one so that their raw surfaces are brought into contact and fastened together with sutures.

Finally, the fistula established in the perineum is closed.

HYPOSPADIAS.

The deformity known as hypospadias is characterized by a congenital abnormal opening of the urethra upon the under surface of the penis. Sometimes the urethra ends at the abnormal opening, sometimes it is continued more or less imperfectly beyond it either in the form of a tube, which is usually imperforate at one or two points, or in that of a gutter. The varieties of hypospadias are usually classified in three groups, the balanic, penile, and scrotal, according as the abnormal opening is found at a point in the urethra corresponding to the glans, the pendulous portion of the penis, or the scrotum. The balanic is the most frequent and least important, and the penile is less frequent and less important than the scrotal. The defect never extends further back than the bulb of the urethra, and consequently never causes incontinence of urine. In the scrotal

and in some of the penile varieties the anterior portion of the urethra forms a tense fibrous cord binding down the glans, curving the body of the penis upward, and preventing its erection.

In the balanitic variety, when the anterior portion of the urethra exists in the form of a gutter, no treatment is required unless the opening is too small. The slight deficiency in length involves no loss of function, and attempts to reconstitute the defective portion of the canal by some plastic operation usually fail. In fact, if the canal exists between the meatus and the abnormal opening, it is better to slit it up than to try to close the latter.

The scrotal variety is considered irremediable, and has never been the subject of surgical interference. In it the scrotum is bifid, the penis usually very small, and the urethral orifice at the bottom of an infundibulum resembling a vulva. Individuals thus deformed have often been mistaken for hermaphrodites and sometimes for females.

In the penile variety, when the anterior portion of the urethra is normal, the opening may be closed by freshening the surface about its edge and covering it with a flap taken from the adjoining skin. When the anterior portion exists only in the form of a more or less shallow groove, it may be transformed into a complete canal by one of the methods of urethroplasty hereinafter described. The two other modes of operating, urethroraphy and perforation, have now been discarded; in the former the edges of the groove were pared and brought together with sutures, in the latter a trocar was passed along through the tissues of the under side of the penis from the extremity of the glans to the abnormal opening of the urethra, and the route thus created kept open by the frequent passage of sounds.

If the penis is incurvated it must be straightened as a preliminary to any operation. To accomplish this it is not sufficient to divide only the fibrous band on its under surface, for the retraction is partly maintained by the shortness of the inferior portion of the sheaths of the corpora cavernosa and the septum between them. If the skin on the under surface is flexible enough to allow the penis to be straightened after the internal bands have been divided, this division may be made subcutaneously, following the

example of Bouisson, by introducing a tenotome and pressing its edge against the sheath of the corpora cavernosa and the septum while the glans is drawn steadily away from the scrotum. Ordinarily, however, this is not possible, and one or two transverse incisions one centimetre long must be made through the skin and deeper parts. By the straightening of the penis these transverse incisions are transformed into longitudinal ones, and their sides are then drawn together by sutures. Several months must then be allowed to elapse before the subsequent plastic operation is undertaken, in order that the cicatrix may become perfectly soft and attain its full vitality.

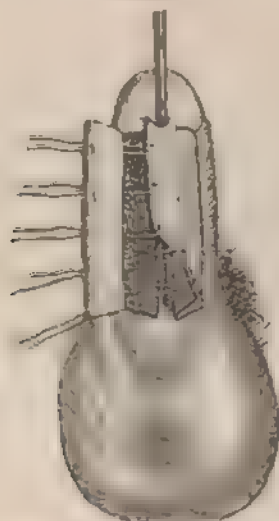
In the earlier operations of *urethroplasty* the floor of the urethra was formed by a long narrow vertical flap taken from the scrotum, its base adjoining the orifice of the urethra, and its borders fastened to the edges of two longitudinal incisions on the under side of the penis. In short, the method resembled that already described as employed by Nélaton for the relief of epispadias, even to the reinforcement of the flap by a transverse one taken from the skin above the root of the penis. The results of these attempts were so unsatisfactory that when Nélaton was consulted, in 1872, concerning a patient affected with hypospadias, he advised that nothing should be done, saying that he had made many canals through which the urine was carried to the end of the penis, but they interfered with erection, and did not facilitate fecundation.* The surgeon who received this advice, Théophile Anger, thereupon devised another method, ignorant that a similar one had been employed shortly before by Thiersch in epispadias and by Seymanowski for urethral fistula, and, having put it into execution, obtained an excellent result.

Théophile Anger's Method In this case the urethral opening was at the peno-scrotal angle, the anterior portion of the canal was entirely lacking, and the penis was so curved that the extremity of the glans was not more than half an inch from the opening. The penis was first straightened by two short transverse incisions carried to such a

* Théophile Anger in Bull. de la Soc. de Chirurgie, séance du 21 Janvier 1874

depth that the corpora cavernosa were exposed at the bottom of the wound; the bleeding was slight, and the wound healed promptly. The plastic operation was performed nearly four months afterward, and was only partially successful, the posterior portion of the flap disappearing by absorption. A second operation, six months later, was entirely successful, and the condition of the parts, when the patient was shown to the Société de Chirurgie five months afterward, was entirely satisfactory; the tissues were supple, there was no stricture in the canal, and erection was perfect, except for a very slight incurvation downward.

FIG. 250.



HYPOSPADIAS. Thiéophile Anser's method

The first plastic operation was as follows: An incision, extending from the glans to the scrotum, was made through the skin on the left side parallel to the median line and one and a half centimetres from it, and from each extremity of this an oblique incision was carried to the median line, the posterior one ending on the scrotum just behind the urethral opening (Fig. 250). The cutaneous flap circumscribed by

these three incisions was dissected up so that it could be turned back with its epidermic surface directed inward, and thus constitute the floor of the new canal. A second longitudinal incision was then made a little to the right of the median line, parallel to and as long as the first, a transverse incision one and a half to two centimetres long carried outward from each end of it, and the flap thus circumscribed dissected up.

A sound was then introduced into the urethra, the first flap drawn back over it, and six sutures placed close to its free longitudinal border; the two ends of each suture were then attached to a needle and carried through the base of the second flap from within outward, as shown in the figure, drawn tight, and fixed by pinching a tube of lead upon them. Finally, the second flap was drawn over the first, and its edge made fast to the outer lip of the first incision, thus covering in all the raw surface.

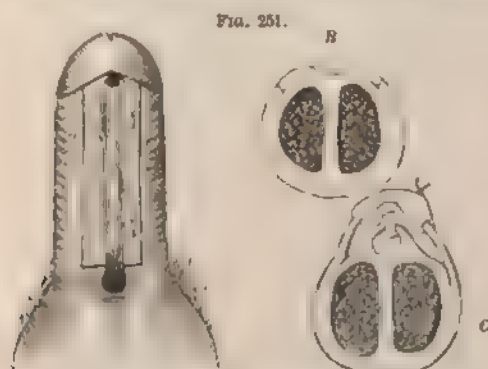
Anger tied in the catheter and left it for several days, but admits that this was a mistake. When he repeated the operation he left the catheter in for only twenty-four hours, and then reintroduced it only when the urine had to be drawn off.

Duplay's Method. The operation has three steps or stages. In the first, the penis is straightened and a mentus made; in the second, the portion of the urethra which is lacking is restored; and, in the third, this new portion is united to that which previously existed.

First Step. The penis is straightened by transverse or subcutaneous incisions as before described, and the mentus made by paring a strip of the surface of the glans on each side of the groove representing the urethra, and bringing them together with one or two points of twisted suture over a piece of gum catheter placed in the groove. If necessary, the groove may be deepened by one or two longitudinal incisions on its floor (roof of the urethra).

Second Step. Two longitudinal incisions, extending from the glans nearly to the abnormal urethral opening, are made, one on each side of the median line, at a distance from each other equal to the circumference to be given to the new urethra; and from each end of these a short transverse incision is made toward, but not quite to, the median line

(Fig. 251, *A*). The rectangular flaps thus circumscribed are dissected up toward the median line, turned back over a gum catheter, and their free borders fastened together with sutures (Fig. 251, *B* and *C*). The outer lips of the two incisions are then loosened sufficiently by dissection to allow them to be drawn over the others and fastened together in the median line with interrupted or twisted sutures.



Hypospadias. Duplay's method.

Care must be taken to attach the anterior ends of all four flaps to the pared surface of the glans, so that the new urethra may be continuous with the piece previously made.

Third Step. To close the gap between the termination of the old and the beginning of the new portions of the urethra, Duplay freshened the edges and brought them together with double rows of sutures.

URETHRAL FISTULÆ.

Urethral fistulæ, as a rule, are more difficult to close the further they are from the bladder. Those occupying the perineum and scrotum are long, pass through thick tissues, and will usually heal spontaneously if the full calibre of the urethra in front of them is maintained. Occasionally it becomes necessary to freshen their sides with a knife, caustics, or cautery.

Fistulae occupying the pendulous portion of the penis have but little tendency to close spontaneously, unless they are recent and small; the distance between the mucous and cutaneous surfaces is so short that the walls of the fistula cicatrize promptly without uniting, and that renders a spontaneous cure practically impossible. Operations undertaken for the purpose of closing them, exclusive of simple cauterization, are divided into two classes, *urethroraphy* and *urethroplasty*. In the former, the sides of the fistula are pared and brought together in the median line; in the latter, the loss of substance is made good by the transfer of cutaneous flaps.

It has always been held that the principal obstacle to the closure of a fistula is the frequent passage of urine through it, and although this has been occasionally questioned, especially with reference to normal, unaltered urine, it is still considered one of the principal indications to prevent this passage. The choice lies between three methods: 1st. Introducing a catheter and drawing off the urine as often as it becomes necessary to empty the bladder; 2d. tying in a catheter; 3d. establishing a free passage for the urine at some point on the proximal side of the fistula. Each method is open to serious objections; the frequent passage of the catheter is calculated to disturb the adjustment of the flaps, stretch the sutures, and irritate the urethra; and, moreover, a small quantity of urine is sure to escape through the canal beside or behind it. A catheter retained in the urethra for several days is even worse; as Ducamp¹ pointed out more than fifty years ago, it violates the two conditions necessary to the cicatrization of every wound, moderate degree of inflammation and of humidity, by irritating the canal, provoking an excessive flow of mucus, and acting upon the wound itself as a pea does in an issue. After two or three days at the latest it not only fails to remove the urine as fast as it collects in the bladder, but actually favors its escape alongside and through the wound. It excites cystitis of the vesical neck, and sooner or later gives rise to the complex of symptoms known as urinary fever. In short, it is not only inefficient after the first day or two,

¹ *Traité des Hémorrhies d'Urine* 1826, p. 237 quoted by Verneuil.

but is positively harmful. The objections to the third method, unless perineal fistula exist and can be sufficiently enlarged, are that as usually practised it involves a considerable wound in the perineum, which may itself give rise to a fistula more obnoxious than that which it is designed to cure, and that by destroying the integrity of the spongy tissue of the bulb it may cause dribbling and imperfect ejaculation of the last of the urine.

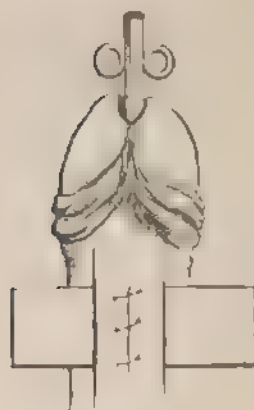
Urethroraphy. This term is applied to the simple approximation of the sides of a fistula after they have been pared. Verneuil¹ considers the method applicable to all circular fistulae not more than one-fifth of an inch in diameter if the surrounding tissues are thick, and also to oblong fistulae of much greater size when their long axis is in the median line and their sides can be easily brought together. He thinks the numerous failures which have followed the use of the operation have been caused by a lack of attention to details, and he suggests that the paring of the edges should be oblique so as to give the fistula the form of a funnel with its apex at the opening into the urethra, the mucous membrane of which should not be included in the paring. Fine metallic sutures should be used, applied at short intervals, not penetrating to the canal of the urethra, and tied over a leaden plate on the surface. The line of reunion should be longitudinal, not transverse, and if primary union is not obtained the sutures should be retained to favor secondary union. During the operation a sound should be kept in the urethra in order that the canal may have its full size.

Urethroplasty. The methods that have been suggested and employed have been very numerous, but most of them count more failures than successes. This is especially true of those by which longitudinal or transverse flaps have been dissected up on opposite sides of the fistula, and brought together by their edges across its centre, for the tissues are usually too thin to afford a sufficiently broad surface of coaptation, and the urine finds its way at once through the wound. It has been proposed to overcome the latter ob-

¹ *Chirurgie Réparatrice*, p. 696.

stacle to union by passing a piece of thin India-rubber under the flaps (Fig. 252), but it is doubtful if the presence of the foreign body would not have a more unfavorable effect upon the thin, delicate flaps than the urine which it is designed to keep away.

FIG. 252.



Urethroplasty

FIG. 253.



Urethroplasty Nélaton.

Nélaton's Method. Nélaton pared the edges of the fistula and dissected up the skin subcutaneously for about an inch around it by entering the knife through a short transverse incision below it (Fig. 253). The skin thus liberated was pinched up in a longitudinal fold along the median line, and fixed in this position by twisted or quilted sutures.

Reynard made the dissection through the fistula, thus avoiding the transverse incision of the skin. **Diesfeldbach** and **Delore** employed a similar method, but instead of dissecting up the skin subcutaneously they raised two longitudinal or transverse flaps and fastened them together by their raw and under surfaces (not edges) in the centre, the former passing his sutures through a leather splint on each side, the latter applying them in three rows, one above the other.

Delpsch and *Alliot* dissected up a single flap, drew it entirely across the fistula, and fastened it to a raw surface prepared upon the opposite side.

Sir Astley Cooper cut away the skin in such a manner as to leave a raw surface of quadrilateral form with the fistula in its centre, and then covered it with a flap of the same shape, taken from the scrotum by the Indian method of autoplasty.

*Arnaud*¹ obtained a complete success in a remarkable case, where the urethra had been completely divided just in front of the peno-scrotal angle, and its two cut ends were nearly an inch apart, by adapting a method previously employed by *Roux* to close a fistula in the trachea. The principle is the same as in *Delpsch's* method, the difference in detail being that two flaps are used instead of only one; the second one, that which has its cutaneous surface pared, being drawn under the first.

Two transverse flaps, one in front of the fistula, the other behind it, were marked out by longitudinal incisions four centimetres apart; the anterior one was dissected up for a distance of two centimetres toward the glans, and the posterior one dissected back over the scrotum, until it could be easily drawn forward far enough to cover the fistula entirely. The anterior portion of the cutaneous surface of the second (scrotal) flap was then thoroughly pared, the flap drawn forward so as to cover the fistula, and the anterior flap drawn back over the other and fastened there by four points of twisted suture.

Sédillot dissected up a small flap on each side, its base adjoining the edge of the fistula, its free border directed outward, reversed and united them by their free borders in the median line (their epithelial surfaces directed inward), and brought the sutures out through the meatus. The raw surface of the flaps was then covered by a third flap transferred by the Indian method, or by sliding.

Rigaud closed a large fistula at the peno-scrotal angle by the method already described as *Nélaton's* method of treating epispadias. He took a quadrilateral median flap from

¹ *Bull. de la Société de Chirurgie*, 1857, p. 550, and *Vernouil's Chirurgie Reparatrice*, p. 654.

the scrotum, its base adjoining the fistula, turned it forward over the fistula, and covered its raw surface with two flaps taken from the sides and drawn together to meet in the median line.

Théophile Anger has likewise proposed to close urethral fistulae by the method he employed so successfully in a case of hypospadias; and

*Szymonowski*¹ reports a success obtained by a method which differed but slightly from Anger's. He made the flaps much longer than the fistula, and freshened the cutaneous surface of the reversed flap by blistering it, so that it could unite with the raw surface upon which it was laid.

Dr. McBurney, by the use of methods similar to the last named, has obtained a number of brilliant successes in urethral fistula and hypospadias; several of the cases are reported in the proceedings of the New York Surgical Society between 1881 and 1884. In cases in which previous operations had failed and had left cicatricial tissue about the opening he sought to close, he first removed the cicatricial tissue and supplied its place with flaps taken from the adjoining skin. To close the openings he used flaps similar to Anger's (Fig. 250), leaving the epidermis upon the surface of the one first turned in over an area corresponding exactly to the opening, and freshening with the knife all the remaining portion of its surface. He also dissected up for a line or two the anterior edge of the central unfreshened portion and tucked it under the freshened anterior margin of the opening.

INTERNAL URETHROTOMY.

Every antiseptic precaution is necessary. A stricture in the penile urethra is conveniently divided under cocaine by the Otis urethratome up to any desired size; the bladder may then be washed with a sterilized saturated solution of boric acid, about four ounces of which are left in. The passage of full-sized sounds must be kept up subsequently.

For anterior strictures too tight to admit this urethratome, and for deep strictures, with the observance of certain

¹ Handbuch der Operativen Chirurgie, 1876.

precautions, the instrument of Maisonneuve is very useful. The flexible filiform bougie is passed through the stricture and secured to the staff, which then follows the bougie into the bladder, and the stricture is divided by slipping the knife along the whole length of the groove while the penis is drawn out on the staff to straighten and render tense the urethra, care being taken to make the section exactly in the median line of the roof. The knife is blunted on its summit and is supposed to divide only the narrowed

FIG. 254.



McBurney's gorget and grooved sound.

portions of the canal. After a stricture beyond four and a half inches from the meatus has been cut in this way, the patient is placed in a lithotomy position, the perineal region thoroughly disinfected and shaved, and a broadly-grooved staff, about the size of a No. 28-30 F. sound, is passed to the bladder. It is so held in the median line by an assistant as to make the curved part of the staff prominent in the perineum. McBurney's gorget (Fig. 255), with the knife protruded, is then plunged into the centre of the peri-

neum, opening the membranous urethra and striking the groove in the staff, into which the gorget is pushed, sheathing the knife, which is then withdrawn, while at the same time, by slightly tilting the staff and advancing the gorget, the latter slips into the bladder as evidenced by the gush of urine. A soft rubber catheter is inserted into the bladder on the gorget through the perineal puncture and retained by a silk suture through the skin, and the gorget is withdrawn. The bladder and urethra are thoroughly irrigated with a saturated solution of boric acid, and the catheter connected with a tube terminating beneath the surface of a 1:60 solution of carbolic acid in a bottle under the bed. A very slight dressing retained by a split T-bandage around the catheter is sufficient, and at the end of five days a sound is passed through the whole length of the urethra entering the bladder alongside of the catheter, which if all goes well, is removed twenty-four hours later, and a single antiseptic pad placed on the punctured wound in the perineum.

When the bladder and urine are not extensively diseased and there are no other complications, such as multiple fistula, this method of treating deep strictures is generally preferred to the usual external urethrotomy.

EXTERNAL PERINEAL URETHROTOMY.

A. With a Guide. Prof. Syme, who introduced this operation, employed as a guide a staff, the straight portion of which was of full size, and its curved portion much smaller and grooved on the convexity. The change from the full to the small size was abrupt, not gradual (Fig. 256). This instrument has been superseded, in the United States at least, by the tunnelled instruments introduced by Prof. Van Buren,¹ which are passed into the bladder over a fine whalebone bougie as a guide, the beak of the instrument being bridged over or drilled out for a distance of about one-quarter of an inch, so that it can be slipped over the bougie (Fig. 255). If a Syme's staff or

¹ Van Buren and Keyes, *Genito-Urinary Diseases*, p. 127.

a tunnelled catheter cannot be had, any instrument may be used which can be got into the bladder, but it is a great advantage to be able to pass a full-sized instrument step by step as the stricture is divided.

The patient is placed in the lithotomy position (dorsal decubitus, thighs flexed upon the abdomen,¹ ankles made fast to the wrist, the perineum shaved, the whalebone guide introduced into the bladder, a tunnelled silver catheter of full size, grooved on the convexity,

FIG. 255.



Syme's staff for perineal section.

passed down over it to the stricture and confided to an assistant, who also draws the scrotum forward out of the way. An incision, varying in length according to the position of the stricture, is made in the median line, and the end of the catheter exposed. If the stricture is deeply placed the sides of the incision must now be held apart by means of two stout ligatures passed through them, one on each side, while the guide is carefully followed from before backward with short cautious strokes of the knife in the median line, and the catheter pushed along as the route

FIG. 256.



Tunnelled instrument and whalebone guide.

¹ A convenient method of keeping the thighs fixed is to pass a stout cane under the knee and fasten it with a cord or roller bandage passed from one end around the patient's neck to the other end. An instrument has been specially constructed for the purpose (Fig. 257), but a stout stick does very well.

is opened, until the posterior limit of the stricture having been passed, it slips into the bladder. Care must be taken not to divide the whalebone guide by a careless stroke of the knife.

FIG. 257.



Clover's crutch, for operations upon the perineum

If Syme's staff is used, the incision is carried down until the groove in the curve of the staff can be felt by the finger; the handle of the staff is then grasped with the left hand, the point of a narrow bistoury passed into the groove behind the stricture, and the latter divided by cutting from behind forward.

Any bands that are found on the roof of the urethra must be divided, and a full-sized steel sound passed to make sure that the stricture has been thoroughly relieved.

B. Without a Guide. The cases are very rare in which a filiform whalebone bougie cannot be passed through a

stricture which allows urine to pass, and consequently external urethrotomy without a guide is not often required. The patient is placed in the lithotomy position, the perineum shaved, and a full-sized catheter passed down to the stricture and confided to an assistant, who also draws the scrotum forward, keeping its raphe exactly in the median line. An incision, two and a half to three inches long, is made in the median line, and the end of the catheter exposed by opening the urethra one-quarter of an inch in front of the stricture. The catheter is then partly withdrawn, the sides of the wound held widely apart by means of stout ligatures passed through them, and an effort made to pass a fine probe or whalebone bougie through the stricture from before backward; if the effort succeeds, the operation becomes one "with a guide," and is completed as before described. If the probe can be passed for only a short distance, a line or two, the tissues are divided upon it, and the attempt renewed until the canal behind the stricture is reached.

If these efforts fail entirely, the urethra must be sought for behind the stricture—a most difficult task unless a perineal fistula exists through which a guide can be passed into the bladder, or unless this portion of the urethra is distended with urine and can be punctured in the median line. Van Buren and Keyes¹ recommend that the surgeon should feel for the hole in the triangular ligament, and cut into it through the fibrous mass by repeated strokes with the knife, always in the median line. Others prefer to pass the index finger of the left hand into the rectum, place it against the apex of the prostate, and continue the dissection backward with a view to opening the urethra at that point. When this has been accomplished, a sound is passed from behind forward to the posterior face of the stricture, and the latter divided as thoroughly as possible between the two sounds.

If the stricture lies in front of the triangular ligament, the centre of the arch of the pubes is an invaluable guide, toward which the incisions should be constantly directed.

Perineal Urethrotomy for Exploration of the Bladder (Thompson). The instruments needed are a median grooved

¹ Diseases of the Genito-Urinary Organs with Syphilis, p. 125.

staff and a long straight, narrow-bladed knife, with the back blunt to the point. Having placed the left index finger in the rectum and introduced the staff, the knife is introduced, edge upward, about three-quarters of an inch above the anus, with or without a small preliminary incision of the skin, until the point reaches the staff about the apex of the prostate, where it divides the urethra for half an inch, and is then drawn out, cutting upward a little in the act, but so as to avoid any material division of the bulb. The index finger is then slowly passed into the bladder through the wound as the staff is withdrawn, and the interior of the bladder explored with the aid of firm pressure above the pubes with the other hand.

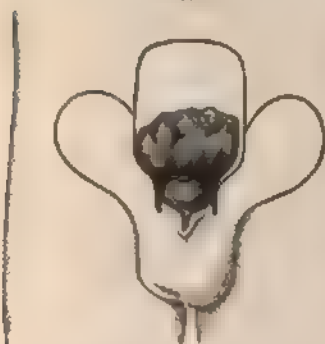
EXSTROPHY OF THE BLADDER.

The first operation for the relief of this deformity was performed, according to Gross, by Prof Pancoast, of Philadelphia, in 1858; according to Erichsen, by Dr. Daniel Ayres, of Brooklyn, in 1859. The deformity is much more frequent in males than in females, and the operative indication is to cover in as much as possible of the exposed mucous membrane and facilitate the adaptation of a urinal by making the urine escape through a comparatively small opening; for, as the sphincter cannot be restored, there will always be incontinence. The method employed is the same as Nélaton's for epispadias: a tegumentary flap is raised from the abdomen above the bladder, reversed so as to cover the latter, and then covered itself in turn by lateral flaps, one from each side.

The first flap (Fig. 258) should be square, its base adjoining and slightly broader than the upper margin of the opening, its length should be sufficient to cover in the bladder completely when turned down over it. A pyriform flap is dissected up on each side, its breadth equal to the length of the first flap, and its base directed downward and inward, as shown in Fig. 258, or downward and outward so as to require less twisting and include more of the cutaneous branches coming from the femoral artery. These two flaps are then drawn across the reversed umbilical flap,

meeting in the median line, and are fastened to each other with twisted sutures, the pins including a portion of the thickness of the umbilical flap also, so as to keep the raw surfaces in contact (Fig. 259).

FIG. 258.



Wood's operation for exstrophy of the bladder.
Incisions.

FIG. 259.



Flaps in place

The edges of the gaps left by the removal of the flaps are drawn together as well as possible with twisted and wire sutures, broad strips of adhesive plaster applied to give support and relieve tension, and the patient kept in bed in a sitting posture with the knees drawn up. The sutures may be removed at the end of a week. Healing may be hastened by using Thiersch skin grafts on granulating surfaces.

When the symphysis is absent Trendelenburg first performs an operation to remedy the epispadias. Later he divides the sacro-iliac synchondrosis on each side from behind forward, sufficiently to mobilize the iliac bones and allow the gap in front to be closed by pressing together the sides of the pelvis. Subsequently the margins of the defect in the soft parts are freshened and brought together with sutures. This may need to be supplemented by a flap operation and Thiersch skin grafts.

Czerny, starting at the edges of the defect, frees the mucous membrane from the underlying parts and sutures its margins together to form a closed sac. Then this is

covered in by two lateral flaps, base down, as in the first operation described. Afterward the neck of the bladder and the freshened edges of the prostatic portion of the urethra are brought together, and then the epispadias is attended to.

A perfect result in this condition is an impossibility. Even if no fistulæ persist the sphincter will not, at the best, be of much value, and the wearing of some sort of urinal is a necessity.

CATHETERIZATION (WITH CURVED METAL CATHETER).

The obstacles to the passage of a catheter, exclusive of stricture and of false passage, are found either at the triangular ligament in the membranous or in the prostatic portion of the urethra. As the fixed portion of the canal begins anteriorly at the opening in the subpubic or triangular ligament, the flaccid pendulous portion in front of this point may be carried aside if the catheter is held improperly, and doubled upon itself in front of the beak of the instrument, thus forming a sort of pouch or cul-de-sac which arrests the progress of the catheter. This difficulty is overcome by drawing the penis gently up the shaft of the instrument so as to straighten out the portion of the canal yet to be traversed, and by keeping the beak in the median line and making it follow the roof rather than the floor of the urethra, so as to avoid especially the normal pouch-like dilatation found on the under side just in front of the opening in the ligament.

The obstacle in the membranous portion is caused by the spasmodic contraction of the muscles which envelop this part of the canal. The nature of the obstruction is recognized by the tight grasp of the instrument by the muscles, the quivering of the fibres transmitted through it to the hand of the surgeon, and by the knowledge of the fact that the instrument has reached this part of the canal where organic obstacles do not often exist. The difficulty is overcome by making gentle pressure with the beak of the catheter in the proper direction, so as to tire out the muscles.

The most serious obstacle is found in the prostatic por-

tion, and is due either to inflammatory swelling of the mucous membrane or of the gland (abscess of the prostate), or, much more commonly, to senile change in the shape and size of this organ. A description of the nature of these changes and lesions does not come within the scope of this work, and the reader is referred for them to special treatises upon the subject. It is sufficient here to say that in the former case the inflammation must be reduced or the abscess evacuated *secundum artem*, or, failing this, the bladder must be punctured above the pubes, or through the rectum. In the other case, catheters of different curves should be tried, such as Mott's long catheter of large curve, or Mercier's soft, single or double-elbowed catheter (Fig. 260). It is also well to pass the forefinger of the left hand into the rectum to make sure that the catheter has entered at the apex of the prostate, and that it has not passed out of the canal into a false passage, and to try to lift its beak over the obstacle by making direct pressure upon the curve in front of the prostate, while the handle is simultaneously depressed.

If these means fail, and soft instruments of gum or vulcanized rubber cannot be introduced, the bladder must be punctured.

Passage of the Catheter. The patient having been brought to the side of the bed or placed upon a lounge, the surgeon, standing on one side, preferably the left, separates the lips of the meatus with the thumb and forefinger of the left hand, introduces the beak of the catheter, previously well warmed and oiled, and passes it down to the peno-scrotal angle, holding the shaft of the instrument parallel to the groin. He then sweeps the handle around to the median line of the abdomen, keeping it close to the surface, draws the penis gently up the shaft, and presses the instrument bodily downward toward the feet; as soon as the beak reaches the lower border of the symphysis he draws the scrotum up and presses the catheter gently onward, still holding it parallel to the body, and then when the beak has closely approached or

FIG. 260.

Mercier's
double-
elbowed
catheter

engaged in the opening in the triangular ligament he gradually raises the handle, brings it forward in the median line, and depresses it between the thighs. Failure to enter the opening in the triangular ligament is indicated by the bulging of the curve of the instrument in front of the symphysis, its rebound when the slight pressure on the handle is removed, and the mobility of the beak when the handle is gently rotated about its longitudinal axis.

As the shaft passes the vertical line the root of the penis and the integument covering the symphysis should be pressed down with the palm of the right hand laid broadly upon it, so as to stretch the suspensory ligament.

PUNCTURE OF THE BLADDER.

Above the Pubes. The only instrument required is a straight, or, better, a curved trocar and cannula, the trocar having a groove in its side which permits a small stream of urine to pass as soon as the bladder is reached. The surgeon satisfies himself by percussion that the distended bladder rises well above the pubes, and then making the skin tense with the thumb and fingers of his left hand, he plunges in the trocar close above the symphysis pubis in the median line, the concavity of the instrument turned toward the bone.

Some surgeons prefer to make a preliminary incision in the median line, and others (Holmes) even continue the use of the knife until the bladder can be felt at the bottom of the wound.

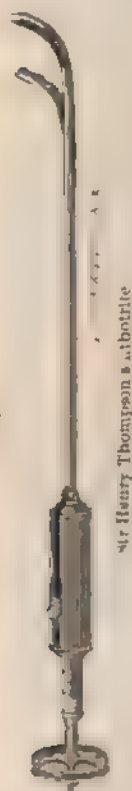
LITHOLAPAXY.

It is the operation of introducing a lithotrite into the bladder through the urethra and with it crushing a stone into fragments, which are then removed by the wash bottle and evacuators represented in Fig. 266.

The modern lithotrite is a steel instrument consisting of a straight shaft eleven inches in length, having at one end a "beak" about an inch long inclined at an angle of from 110° to 130° , and at the other a cylindrical roughened

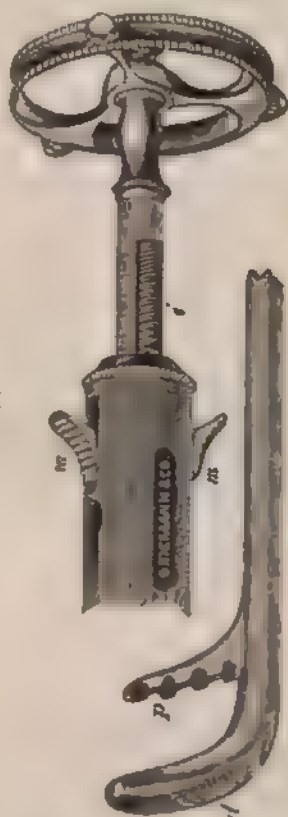
handle containing a screw. It is composed throughout of two parts, one fitting accurately in a deep groove in the other, and having at the handle a male screw which can be thrown into and out of gear by means of a button upon the other part. While trying to catch a stone the screw should be out of gear, in order that the male blade may be advanced

FIG. 201



Mr Henry Thompson's lithotrite

FIG. 202



Mr Henry Thompson's lithotrite

and withdrawn more rapidly, but when the stone has been fairly caught the button must be pressed back and the screw-power used to crush it.

Many different patterns have been proposed for the beak

or jaws with the view either of securing the thorough pulverization of the fragments, or of preventing the clogging of the instrument by the impaction of the mortar-like detritus between the jaws. The latter difficulty can be overcome by leaving the jaw of the female blade entirely open, that is, with a large fenestra extending from side to side and from the extremity of the beak to its angle, and by making the male blade long enough to allow its jaw to be passed entirely through the female one and even to project beyond its convex surface. In its simplest terms, then, the jaws should consist of two parallel bars, one-fourth of an inch apart, between which a third one, fitting loosely in the gap, can be forced. Of course, the male jaw must not be allowed to project beyond the convex surface of the female one during its passage through the urethra.

A small fenestra at the angle of the beak will not prevent clogging, although it may diminish it if there is a corresponding projection at the heel of the male jaw, as in

FIG. 263.



• Scoop. • Lithotrite.

Fig. 263; and it is open to the very serious objection that it may lodge a sharp angular fragment, which, projecting beyond its edges, will lacerate the neck of the bladder and the floor of the urethra during the withdrawal of the instrument.

The arrangement of open spaces in the female jaw corresponding to guttered projections or teeth upon the male jaw, as in Reliquet's model, is entirely insufficient to prevent clogging. The detritus picks across the gaps and presents an absolute bar to the closing of the instrument. Whenever

such corresponding teeth and spaces are used they should be cut to fit each other very loosely, that is, with a clear space of at least one millimetre between them.

For catching and crushing small fragments the "scoop" lithotrite is commonly used; the jaw of its female blade is broad and shallow, with no fenestra or with only a small one at its angle. The edges of both jaws should be bevelled, and the male considerably narrower than the female, so that they may be brought together with the least possible danger of including a fold of mucous membrane between them.

Prof. Bigelow,¹ of Boston, recommends an instrument (Figs

FIG. 264



FIG. 265



Bigelow's Lithotrite.

264 and 265) combining, as he claims, the advantages of the fenestrated and the scoop lithotrites. The female jaw

¹ The American Journal of the Medical Sciences, Jan. 1878.

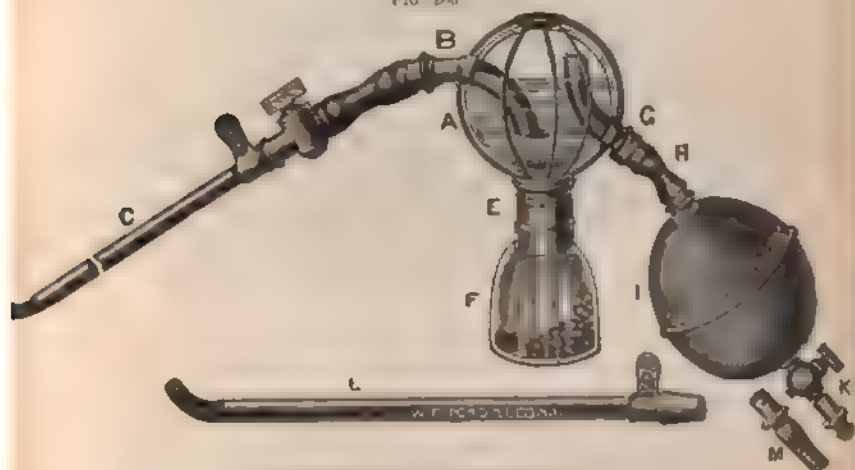
is shallow, so that small fragments are easily caught and crushed in it, and clogging is prevented by deep notches opening outward on the sides of the male jaw (Fig. 265), and by a small fenestra at the angle to provide for the escape of the detritus engaged in the groove of the female blade. He also substitutes for the button on the handle of Thompson's lithotrite, a mechanism partly shown in Fig. 264, by which the screw can be thrown into gear by a turn of the hand holding the end of the male blade; and, further, curves the beak of the instrument to facilitate its passage through the prostatic urethra. It must be admitted, however, that with a soft, phosphatic stone the instrument will become impacted; and when the stone is large and hard the connecting catch is liable to be torn away. I prefer, therefore, the instrument recommended by Prof. Keyes (Fig. 262); it cannot clog, and the lateral catch cannot be broken by any force exerted through the screw.

Operation. The patient is anesthetized and placed upon his back, with his hips raised upon a firm pillow or cushion in order that the stone may gravitate away from the neck of the bladder. If the urine is turbid, and especially if it is ammoniacal, it should be drawn off before the operation and the bladder thoroughly washed with a borax solution (one or two drachms to the pint), of which from two to four ounces should be left in the bladder to facilitate the crushing. The surgeon, standing at the patient's right side, introduces a freshly boiled lithotrite after greasing the instrument with vaseline. Great care must be taken not to depress the handle too soon, a mistake which is likely to be made on account of the apparently great depth to which the instrument has to penetrate before the bladder is reached.

As soon as the instrument has entered the bladder, it is allowed to glide across it, its shaft being held steadily in one position, and if the stone is free it will generally be touched on the way. The surgeon then gently turns the beak away from the stone, withdraws with his right hand the male blade for a distance determined by previous measurement of the stone, presses the jaw of the female blade gently against the floor and posterior wall of the bladder, rotates the beak toward the stone, and closes the male blade upon it. As soon as the stone is felt to be firmly caught,

the beak is rotated back to the vertical position, and the screw thrown into gear by pressing back the button on the handle with the thumb of either hand. The lithotrite with the stone in its grasp is then drawn away from the posterior wall and rotated to either side to make sure that the mucous membrane is not caught between its jaws, and then, grasping the cylindrical handle firmly with his left hand, the surgeon crushes the stone by turning the screw with his right, and continues this action until the register upon the handle shows that the male blade has been driven well home. The screw is then thrown out of gear, the male blade drawn back, the beak turned again toward the spot where the stone was caught, and the instrument closed whether the fragments are felt or not, for it may be confidently expected that they will be found there.

FIG. 256



Evacuating-tube and washing-bottle

After crushing the stone in this manner several times the smaller fragments are washed out by the evacuating tube and washing-bottle (Fig. 256) and the lithotrite reintroduced; and this alternation in the use of the instruments is continued until the bladder is emptied. This frequent washing is important because by the removal of the smaller

fragments it is made easier to seize and crush the larger ones.

The washing is done as follows: The washing-bottle is filled with tepid water, then the tube is introduced, and as soon as the urine begins to flow through it the bottle is coupled to it. Or the coupling may be done just before the tube has entered the bladder, and the air in the tube allowed to rise to the top of the bottle, by turning the stopcock, before the introduction is completed and the washing is begun.

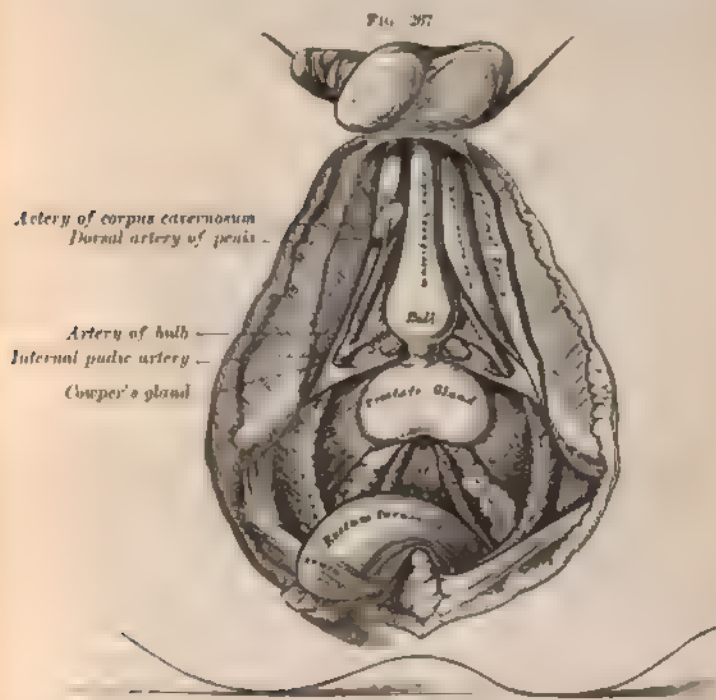
By quick compression and relaxation of the rubber bulb the water is rapidly forced into the bladder and drawn back again, bringing the fragments with it; these fragments sink to the bottom of the bottle and are not returned with the returning stream. The amount of water driven back and forth at each movement will vary with the sensitiveness and distensibility of the bladder; two or three ounces are sufficient to wash effectively. If the curved tube is used, its eye should be in turn directed to different quarters of the bladder; if the straight tube with a square end is used, it must be passed just through the neck, and its outer end well depressed between the thighs.

At the close of the operation the surgeon should place his ear upon the hypogastrium and listen while washing, to detect the click against the tube of any fragments that may remain. This is a much more delicate test than the use of the searcher.

LITHOTOMY.

The anatomy of the perineum is sufficiently well shown in Fig. 267 to render a detailed description unnecessary. It must be remembered, however, that the distance between the anus and the bulb diminishes with advancing years, and that the diminution of the distance is due to an increase in the size of the bulb. The dangers incident to incision of the bulb increase, therefore, with the difficulty of avoiding it. The dimensions of the prostate have been studied with much attention, and have been the basis of many of the modifications of perineal lithotomy, for it has been held, and still is held by many, that the incision should not be

carried beyond the limits of the gland. The greatest radius, measuring from the urethra, is one inclined about 30° backward and downward from the transverse diameter, and in the normal adult prostate this measures about three-quar-

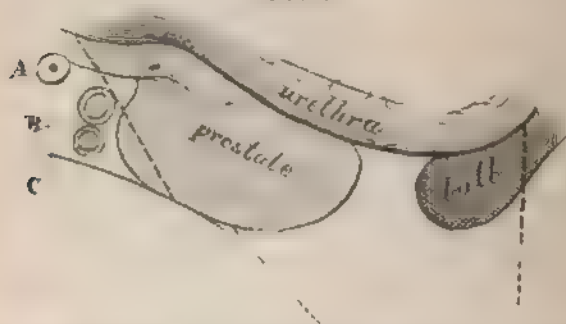


A view of the position of the viscera at the outlet of the pelvis.

ters of an inch at the largest part of the gland, that which adjoins the neck of the bladder. But, as the diameter of the prostate diminishes as the distance from the bladder increases, an incision which remains within its limits at one point may extend far beyond them at another; and this fact, taken in connection with the great variations in the size of the gland, indicates the futility of attempts to regulate the incision with mathematical precision. Fortunately, the depth of the incision is not a measure of the size of the

stone which can be safely removed through it, for the normal dilatability of the neck of the bladder and the prostatic portion of the urethra (to a diameter of two centimetres, according to Dolbeau) is thought to be considerably increased by even slight incisions. Dupuytren thought the opening in the prostate could be greatly enlarged by making an oblique incision on each side (bilateral lithotomy), but the gain has not proved so great as was expected.

FIG. 268.



Incision in lateral lithotomy. the dotted lines mark its limits. A Vas deferens. B Seminal vesicle. C Continuation of the capsule or prostatico-peritoneal ligament.

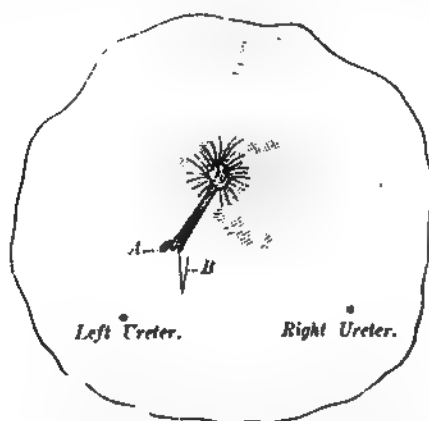
By reference to Figs. 268 and 269, which show the extent of the incision of the prostate and neck of the bladder in lateral lithotomy, it will be seen that the limits of the prostate are exceeded everywhere, the capsule remaining intact, however, for a distance of about half an inch at the thickest part of the gland. The sulcus between the bladder and the prostate is opened, and the bladder wall divided for fully half an inch in the direction of the orifice of the left ureter. These figures are taken from a dissection of a cadaver upon which lateral lithotomy had been performed for the purpose of determining these points.¹

If the stone is large and the tractions made with too much force, the neck of the bladder may be torn off, but more commonly the incision is lengthened by tearing at its outer

¹ The relation was made as if for the removal of a stone one inch in diameter. The cadaver was that of a male about twenty five years old.

end, an accident which is much less dangerous than extending the incision with the knife would be, for it spares the rich plexus of veins about the prostate.

FIG. 269.



Lateral lithotomy. Incision of the neck of the bladder as seen from within. *A* is a rent in the wall made by the introduction of the finger. *B* is an extension of the incision involving only the mucous membrane.

Lateral Lithotomy. The instruments required are a staff with a long curve, deeply grooved on its convexity (Fig. 270), a stout scalpel with a cutting edge of one and one-half inches (Fig. 271), a Blizard's knife (Fig. 272), a blunt gorget (Fig. 273) if the patient is fat, a scoop (Fig. 274), forceps of different patterns (Figs. 275, 276, 277), a syringe and tube for washing out fragments, and a shirted canula (Fig. 278) to control hemorrhage. The latter can be readily made by passing the beak of a female silver catheter through the centre of a piece of iodoform gauze eight inches square, and tying the two firmly together, as shown in the figure. It is then introduced into the wound, the beak of the catheter in the bladder, the pouch tightly packed afterward with pledgets of gauze, and the whole kept in place by a T-bandage. Three assistants, at least, are required: one to administer the anæsthetic, the others to hold the knees and the staff.

FIG. 270.

FIG. 271.

FIG. 272.

FIG. 273.

FIG. 274.



Lithotomy staff.

Gorget

Scoop

*Operation.*¹ The patient, having had his bowels emptied by an enema, is placed upon his back, his ankles bound fast to his wrists (Fig. 279), the staff introduced, and the stone touched with it. It is an absolute rule that if the stone

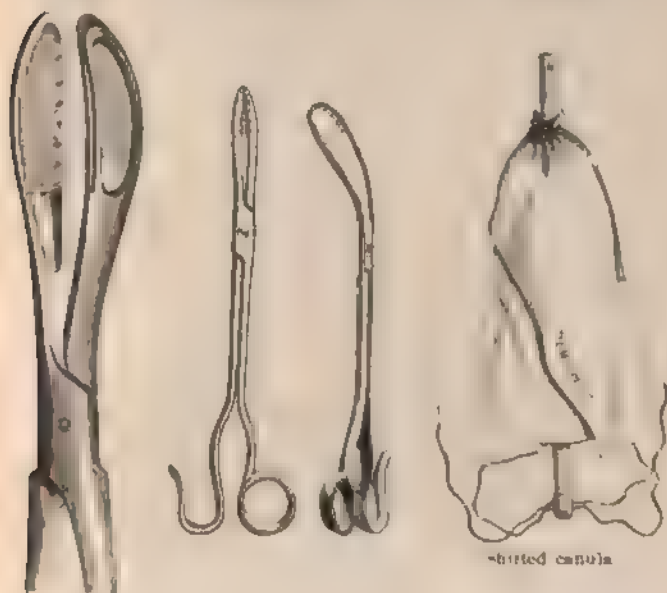
¹ Van Buren and Keyes. *Genito-Urinary Diseases and Syphilis*, p. 552.

cannot be felt with the staff or a searcher after the patient has been etherized and placed upon the table, the operation must be postponed. It is not necessary that the beak of the staff should rest upon the stone during the operation;

FIG. 275

FIGS. 276, 277

FIG. 278



on the contrary, it is better to hook the staff up under the symphysis so as to keep it steady, with its curve bellied out in the median line of the perineum, and the integument stretched over it by drawing the scrotum up around the staff.

The operator passes his index-finger into the rectum, and satisfies himself that the staff enters at the apex of the prostate and passes centrally through it, and that the rectum is empty. Then withdrawing his finger he feels along the raphe of the perineum for the groove in the staff, aiding himself, if necessary, by depressing and raising the handle several times.

Having found the groove he confides the staff to his chief assistant, enters the scalpel a little to the patient's left of the raphe, from one and one-quarter to one and one-half inches in front of the anus, and passes it in almost parallel to the rectum so as to enter the groove about half an inch in front of the apex of the prostate, guiding it, if he thinks

FIG. 219.



Position of patient and line of incision in lateral lithotomy

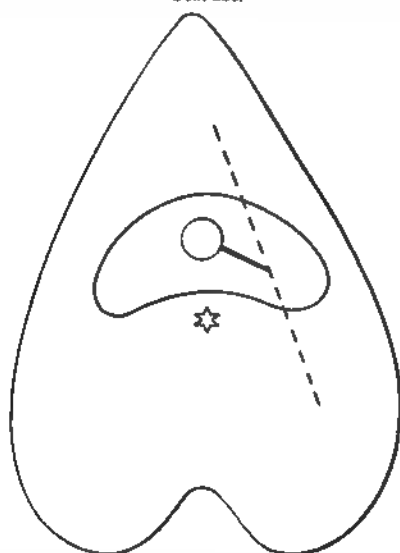
best, by keeping his left index-finger upon the prostate in the rectum. (If the knife should be passed directly in to the nearest point on the staff, the bulb would be involved to an unnecessary extent.) As soon as the point of the knife has entered the groove, it is pushed along for half an inch, dividing the floor of the urethra to that extent, and then withdrawn, cutting steadily downward and outward so as to make a cutaneous incision about three inches long, passing midway between the anus and left tuber ischii.

The probe-pointed Blizard's knife, guided upon the left index-finger, is passed into the groove, and the surgeon takes the handle of the staff from the assistant, depresses it somewhat, and pushes the knife along until its point is arrested at the termination of the groove at the end of the staff. Then depressing the handle of the knife, and bearing in mind the shape and position of the prostate, he

makes an incision in it downward and outward at an angle of about 30° with the horizon (Fig. 280).

The index-finger is next introduced, the staff withdrawn, and the neck of the bladder gently dilated with the finger, or, if the perineum is deep and fat, with the blunt gorget carried in along the groove in the staff. If the stone is more than an inch in diameter, the Blizard knife must be reintroduced and the prostate cut upon its right side also.

FIG. 280.



Lateral lithotomy. Relations of the two incisions to each other and to the prostate. (Thompson.)

The forceps are then introduced as the finger is withdrawn, and the stone sought for by opening and closing the blades at different points on the floor of the bladder; or the small end of the scoop may be introduced, placed in contact with the stone, and the forceps guided along it. If the stone is seized in a faulty direction, it must be dropped and caught again, or straightened with the fingers while still held between the blades. Extraction should be made slowly downward and outward in the line of the external

incision, and aided by lateral movements of the handles. The old rule was that the force used should be two-thirds lateral, one third extractive. If it is found that the stone is too large to be removed without employing too much force, it must be crushed and the fragments removed separately. Small stones and fragments are best removed with the scoop and by thorough washing.

In operating upon children certain modifications are required. The prostate being very small the incision usually passes quite beyond its limits, but this is a matter of slight importance since the ill results which follow in adults and old men do not occur at this age. If the incision in the urethra and at the neck of the bladder is not sufficiently free, it may happen that, in the attempt to introduce the finger, the urethra will be torn entirely across and the bladder pushed up before it. Again, the bladder is placed higher in the child than it is in the adult, and therefore the point of the knife must be more raised in making the deep incision, and care must be taken not to let it slip in between the rectum and bladder. Mr. Erichsen¹ says he has known this to occur in several instances, and the forceps to be passed into this space under the impression that it was the bladder.

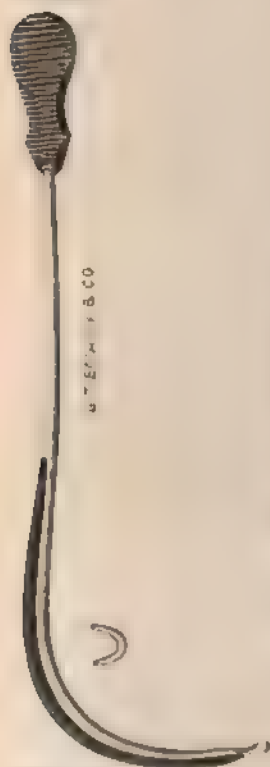
It has also happened to some surgeons to force the beak of the staff through the roof of the urethra into the space between the bladder and posterior face of the pubes, and to be so deceived by its freedom of motion in the loose cellular tissue of that region that they thought it was in the bladder, and cut upon it accordingly.

Median Lithotomy. The only instruments required other than those used in the lateral operation are a staff, director, and knife. The staff has a central, broad, deep groove on its convexity (Fig. 281), the director has a ball-point (Fig. 282), and the knife is straight, stout, and sharp-pointed, with a cutting edge upon the back also for a short distance from the point (Fig. 283).

The patient having been bound in the lithotomy position and the staff introduced, the surgeon places his left index-

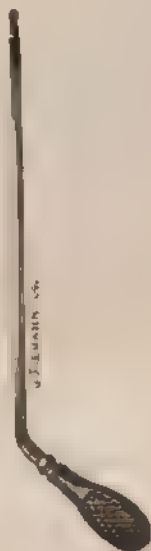
finger in the rectum against the apex of the prostate, and plunges the knife with its edge upward into the raphe of the perineum half an inch in front of the anus in such a direction that its point will enter the groove of the staff just at the apex of the prostate. The knife is pushed very

FIG. 261.



Staff for median lithotomy

FIG. 262.



Ball pointed director

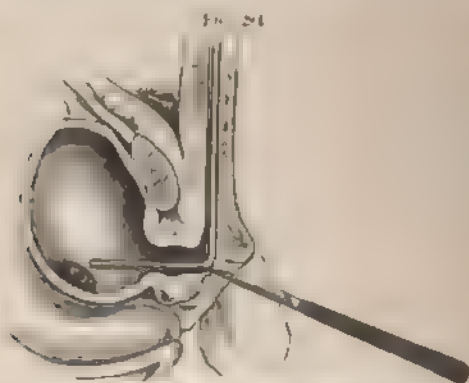
FIG. 263.



Double-edged scalpel

slightly back along the groove so as certainly to open the urethra and nick the end of the prostate, then brought forward, dividing the membranous portion of the urethra, and swept around the bulb by raising the handle, making an external incision upward along the raphe for about one and

a quarter inches. The director is next passed along the staff into the bladder, the two separated angularly to make partial dilatation of the neck, the staff withdrawn, and the dilatation completed with the finger. The forceps are then introduced and the stone removed as in lateral lithotomy.



Median lithotomy with rectangular staff

Sir Henry Thompson makes the incision from without inward, and Mr. Erichsen uses a rectangular staff (Fig. 284), placing its angle close against the apex of the prostate.

SUPRAPUBIC CYSTOTOMY FOR VESICAL CALCULUS.

The patient and the skin surface are prepared in the usual way for an aseptic operation, and after etherization the bladder is irrigated clean with a warm saturated solution of boric acid. The viscus is then distended with as much of this solution as can be injected from an irrigator vessel elevated not more than two feet; such a pressure is harmless, while the injection of a fixed amount of fluid or the use of a hand syringe may not be, owing to the uncertainty as to the capacity of the bladder and the condition of its walls.

The catheter is then withdrawn from the urethra and a thin-walled soft-rubber bag, which is better than the ordinary stiff colicaryuter, is placed in the rectum above the sphincter and cautiously distended by a Davidson syringe,

using not more than eight or ten ounces of water. This simply presses the bladder forward and brings its floor more within reach, but it does not materially alter the relation of the peritoneum to its anterior wall, and hence the use of the colpeurynter can frequently be dispensed with. After filling the bladder it is unwise to constrict the penis, as is so often done, but the urethra should be left free to relieve any excessive strain on the bladder wall.

An incision two or three inches long is then made in the median line from just below the upper border of the symphysis pubis upward in the median line and deepened layer by layer as nearly as possible between the recti, and the underlying fascia is divided.

If more space is required the recti and fascia can be cut transversely to a greater or less extent close to the pubes. The peritoneum does not descend below the urachus, which can sometimes be felt as a cord attached to a knot on the fundus, and by carrying the dissection directly inward through the prevesical fat with blunt-pointed scissors, aided by the finger, and avoiding unnecessary laceration of the tissues, the bladder is exposed; after pushing upward the fatty and cellular tissue which carries the peritoneum with it, a tenaculum is inserted in the highest-exposed part of the bladder wall and a knife is plunged into it just below the tenaculum, opening the bladder longitudinally downward for about an inch. Each side of the incision is immediately grasped by catch forceps which serve to hold the opening in the abdominal wound.

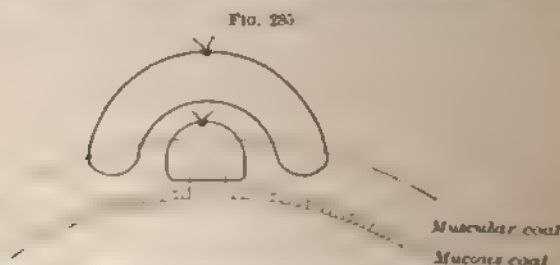
The peritoneum may descend unusually low in front, and this must be recognized in the dissection, which in such cases should be first downward and inward behind the pubes and then up over the anterior surface of the bladder, pushing the unopened peritoneum out of the way; the numerous veins which are encountered are drawn aside or ligated as they are divided, but it is unnecessary to waste time searching for bleeding points, as the hemorrhage generally ceases spontaneously on opening the bladder.

The interior of the latter is then carefully explored by sight and touch, and any loose stones are picked up with instruments, preceded, if necessary, by crushing; the mouth of a diverticulum containing a stone may have to be gently

dilated, but never cut, and the stone scooped or irrigated out, or first nibbled into fragments by forceps; projecting portions of the prostate preventing the free escape of urine are excised as described under prostatectomy, and finally the interior of the bladder is washed free from all clots and *débris* with warm boric solution.

As a general rule, a wound in a comparatively normal bladder wall should be closed with sutures, but if there is much pus or inflammatory change present it is better to leave the wound open.

To insert the sutures a blunt tenaculum is placed in each extremity of the incision in the bladder, lifting up and steadying it. Interrupted sutures of chromicized catgut are then inserted by a fine-curved needle at intervals of a quarter of an inch close to the edges of the wound and passing through the cut surface without entering the thin



Method of suturing a wound of the bladder

mucous membrane; over and between these is placed a row of chromicized catgut Lembert sutures extending a short distance beyond the extremities of the incision, and after all the sutures have been tied the bladder is filled with boric solution to test their efficacy.

Weak points are then reinforced by additional Lembert sutures. An iodoform-gauze packing is placed in contact with this suture line, and if considered necessary one or more rubber drainage tubes can be added; the abdominal wound is then partially closed with silk sutures, a couple of which are left untied till the drainage is removed several days later if all goes well, when the wound can be closed tight.

An antiseptic dressing is applied and a catheter for continuous drainage is fastened in the bladder through a perineal puncture as described under external urethrotomy by McBurney's gorget. Some surgeons prefer to leave the urine to escape by its natural path, or tie a catheter in the urethra for a day or two.

In about half of the properly selected cases primary union of the bladder may be expected.

If the bladder wound must be left open its lips may be temporarily fastened in the margins of the abdominal incision, and the latter is partially closed above and below, while a light iodoform-gauze packing is placed in any pockets which may have become infected around the opening in the bladder. A rubber drainage tube with lateral perforations near its lower extremity is then inserted into the deepest part of the bladder, and the other extremity passing out of the wound is connected with a tube which terminates below the surface of a 1:60 carbolic solution contained in a bottle under the bed.

To favor the intended siphon action of the tube, at its exit from the bladder it is surrounded by a tight iodoform-gauze packing, but still a large proportion of the urine will inevitably escape into the dressings, which will need very frequent renewal; no other drainage is required. The tube is prevented from slipping out by a silk suture passed through it and the skin.

Transverse Incision. If the bladder is very contracted and it is deemed unsafe to use the rectal bag, so that the bladder must be sought at a greater depth than usual, a transverse incision dividing both recti gives easier access to it. This incision, slightly convex downward, is made close along the upper margin of the symphysis and extended about two inches to either side of the median line. After it has been carried through the recti and fascia into the pre-vesical space the subsequent operations are as above described.

Laugenbuch divides the suspensory ligament of the penis and exposes the lower part of the bladder below the pubes by an inverted Λ -incision. The vertical limb lies over the symphysis and the oblique ones follow the edges of the descending rami of the pubes.

PROSTATECTOMY.

Suprapubic. The rectal bag is inserted and filled, and the bladder is opened and washed out, as already described, and if the enlargement is pedunculated it is simply surrounded with or without transfixion by a silk ligature, the ends of which are left long and brought out of the abdominal wound, while the mass is left to slough away or is immediately excised with scissors.

When the projection cannot be ligated it may be removed with the *écraseur* or galvano-cautery. The uniform "collar" projection of the prostate is excised by dividing its margins transversely above and below, and shelling out each semicircular half with the fingers after incising the mucous membrane on the summit of the ridge.

Keyes strongly recommends the use of the *rongeur* forceps to cut away the hypertrophied posterior lip of the orifice. In no case should any portion of the projecting valve be left behind, and finally the patency of the urethral canal is ascertained by the passage of the finger as far as the first joint.

Hemorrhage is controlled by packing with iodoform gauze or by the cautery. At the close of the operation the extremities of the abdominal wound are drawn together around the opening in the bladder, which, if possible, is sutured to the margins of the wound, while all spaces which are liable to infection are packed with iodoform gauze, and a siphon drain is placed in the bladder.

Perineal Prostatectomy. The urethra is opened in the membranous portion for about an inch or an inch and a half by an external urethrotomy, and after inserting a gorget the finger is passed to the bladder by gradual dilatation of the urethra and the projection located and explored. The finger must then be withdrawn to make room for the *écraseur*, galvano-cautery, or one of Thompson's forceps, by which the growth is snared or torn from its attachments.

Hemorrhage is checked by irrigation with very hot or very cold water, or by packing, and the subsequent treatment is the same as for external urethrotomy. This method

is seldom used because of its limited applicability and the difficulty of manipulation.

For hypertrophy of the lateral lobes of the prostate Dittel¹ proposes an incision from the coccyx to the median line of the perineum, passing around one side of the sphincter. The dissection is carried down to the prostate in front and at the sides of the rectum, which is rendered prominent by packing, and a cuneiform section is removed from the enlarged portions of the gland like a tumor, without opening the urethra. The resulting wound is then drawn together with catgut and a strand of iodoform gauze inserted for drainage.

Enlarged Prostate Treated by Castration. Cases of hypertrophied prostate complicated by retention and cystitis have been successfully treated by White, of Philadelphia, and others by castration. The prostate atrophies within a year or less and the obstruction to the escape of urine thus disappears. The operation is simpler and less dangerous than prostatectomy, and the results have been satisfactory.

TUMORS OF THE BLADDER.

The bladder is rendered as aseptic as possible by washing and is then explored by a suprapubic cystotomy. When malignant disease is found lying near the fundus (which is its rarest location), and of limited extent, a sponge is placed in the interior of the bladder to soak up all the urine, and if the peritoneal cavity must be opened to effect a thorough removal of the disease, it is protected by a sponge packing and the bladder wall divided with scissors, including the peritoneum, if necessary, well outside the limits of the growth.

The peritoneal part of the wound in the bladder is then closed by Lembert silk sutures, which must not enter the mucous membrane, the protective packing removed, after thorough cleansing of the abdominal cavity, and the peritoneum above the bladder drawn together with catgut.

¹ Wien med. Woch., 1896, No. 14-19.

The rest of the bladder wound is treated as in simple suprapubic cystotomy.

If the cancer occupies the sides or base of the bladder most surgeons, in this country at any rate, advise against an attempt at radical removal and are content with curetting to ameliorate symptoms.

A few successful cases are reported in which the disease has been removed with the surrounding mucous membrane, but leaving the muscular coat from which the growth is sometimes found separated by a layer of fat.

Helfferich¹ resects the pubes through a transverse incision above the symphysis and so gains access to the anterior surface of the bladder.

Nichans² performs a very similar operation which he calls an osteoplastic resection of the pubes.

Zuckerkandl³ exposes the base and adjacent posterior surface of the bladder by a curved transverse incision through the perineum in front of the anus and rectum, which are turned down and drawn back. (See removal of seminal vesicles.)

Bramann⁴ chisels out a small piece of the symphysis, including the portion connected with the recti, by a T-shaped incision, the horizontal limb lying above the pubes between the cords and the vertical over the symphysis; at the conclusion of the operation the bone is sutured back in position and the patient fixed in a half-sitting position with the legs flexed.

For total extirpation of bladder or its mucous membrane, see *American Journal of the Medical Sciences*, January, 1891, p. 101, and *Wien. med. Presse*, 1889, No. 27-28.

Benign growths which are more or less pedunculated are treated in the manner described for suprapubic prostatictomy and their bases scraped or cauterized or touched with a ten per cent solution of chloride of zinc.

If the tumor has a small enough pedicle, the latter can be grasped by a pair of forceps close to the bladder wall, and the tumor twisted off on the distal side of the forceps, which are held immovable; but unless all portions of the growth

¹ Archiv f. klin. Chir. 1888, p. 625.
² Wien. med. Presse 1889, No. 21-22.

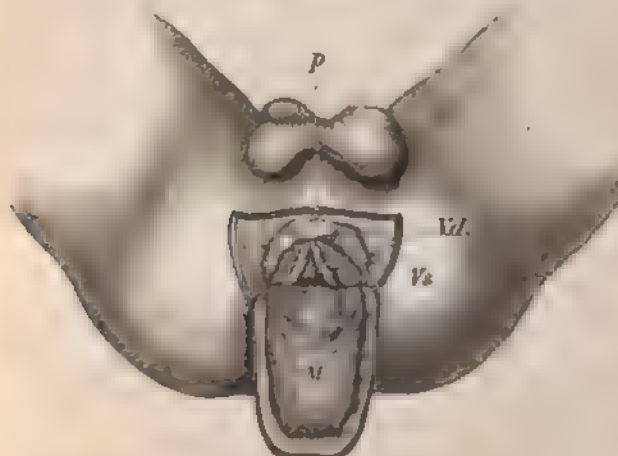
³ Centraltb. f. Chir. 1888, p. 743.
⁴ Centraltb. f. Chir. 1890, p. 1.

are removed it is liable to recur. Benign tumors can occasionally be torn from their attachment by forceps introduced through an external urethrotomy wound, but care must be taken not to force the bladder wall into the grasp of the instrument by pressure on the hypogastrium. There is less danger of rupturing the bladder than might be supposed, owing to the usual hypertrophy of the muscular coat underlying the tumor.

REMOVAL OF THE SEMINAL VESICLES.¹

*Zuckerkandl's Incision.*² The patient is placed in the lithotomy position with a sound in the urethra to mark its position and the bladder partially filled with a saturated

FIG. 290



Zuckerkandl's incision for removal of the seminal vesicles

P Prostate. Vd Vas deferens. Vz Vesicula seminalis. M Rectum

solution of boric acid. A slightly curved incision with its concavity towards the anus is made transversely across

¹ See also: Martin, *Centralb f. Chir.* Feb. 27, 1890.
² *Wien med. Presse*, 1889, p. 826.

the perineum, having its centre about one inch and a half in front of the anus. From each extremity of this a straight diverging incision about an inch and a half long passes back on either side of the anus to end near the tuber ischii. After division of the skin and subcutaneous tissue a finger is placed in the rectum and the perineal septum cut through, avoiding the anterior rectal wall.

The dissection is deepened till above the sphincter ani, which is then turned down with the rectum while the bulb of the urethra is pushed forward, and the pubic portion of the levator ani is divided on each side of the prostate. Free hemorrhage may be expected from the hemorrhoidal and prostatic plexus of veins, but it is easily controlled by pressure or clamps. Then, by tearing through the loose connective tissue, the rectum is easily separated a little more fully from the bladder, the base of which can be made more prominent by manipulating the sound, and the prostate, vasa deferentia, and seminal vesicles are brought into clear view.

It only remains to dissect off one or both vesicles and to ligate the corresponding vas deferens with catgut.

The wound is closed and dressed antiseptically with a rubber drainage tube and light iodoform-gauze packing in its most dependent angles.

The vas deferens, cord, and testicle can be extirpated at the same time by an incision starting over the internal abdominal ring and passing down through the inguinal canal into the scrotum. This incision is deepened layer by layer above the pubes, the peritoneum recognized and pushed up, and then by working with the fingers from above and below (through Zuckerkindl's incision) the vas can be separated from the bladder and pulled out through the opening in the abdominal wall.

CHAPTER VII.

OPERATIONS UPON THE GENITO-UBINARY ORGANS OF
THE FEMALE.

CATHETERIZATION.

THE surgeon, standing on the right side of the patient and holding the catheter in his right hand, with its convexity lying on the palmar surface of the index-finger and its beak not quite reaching to the end of the distal phalanx (Fig. 287), separates the nymphæ with the thumb and middle finger of his left hand, introduces his right index-finger at the fourchette and brings it forward, recognizing the entrance to the vagina and its anterior border, and stopping when he feels the pouting orifice of the urethra. Then keeping the pulp of the finger below and in contact with the orifice he passes the catheter in.

FIG. 287.



Mode of holding the catheter

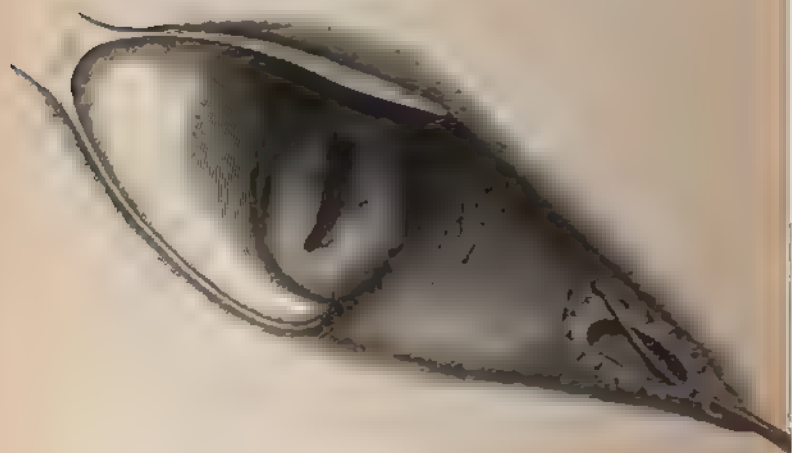
Unless there is some reason to the contrary, this should always be done without exposure of the parts.

EXTERNAL URETHROTOMY.

The Buttonhole Operation (Emmet) (Fig. 288). The patient is anesthetized and placed on the left side, and the

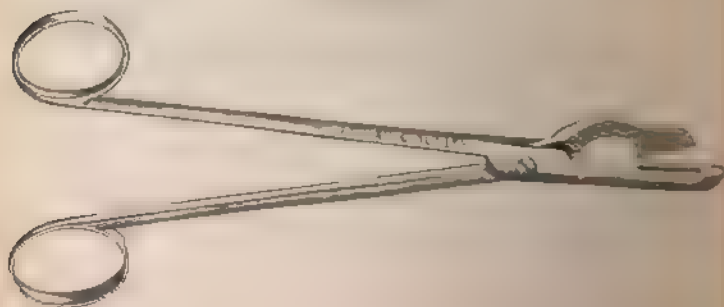
fourchette retracted with a small Sims's speculum. A full-sized metal sound is introduced into the urethra, then the tissues in the vaginal surface are caught up with a tenaculum and divided longitudinally midway between the meatus

FIG. 288.



and the neck of the bladder. The incision may then be extended with scissors. Neither the neck of the bladder

FIG. 289.



nor the meatus should be divided. If the incision is to be kept open, the urethral mucous membrane must be drawn

out through it and stitched with catgut to the edge of the divided vaginal surface. The incision may be conveniently made with Emmet's buttonhole scissors (Fig. 289).

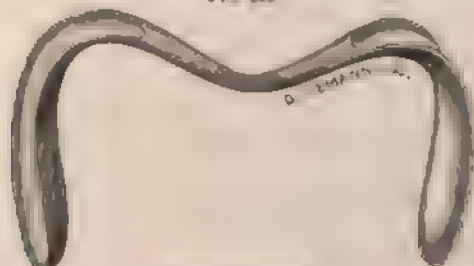
LITHOTOMY.

Besides the *suprapubic*, which is performed in the manner already described, there are the *urethral* and *vesico-vaginal* operations. In the former the stone is removed through the urethra after the calibre of this canal has been increased by an incision along its anterior (upper) wall, or on one or both sides, incisions which do not extend into the vagina. In the latter the stone is removed through an incision made in the vesico-vaginal septum.

Urethral Lithotomy. The only instruments actually required are a director, a probe-pointed knife, and forceps, but some surgeons prefer to make the incision with a single or double lithotome introduced alone or upon a director. Lateral incisions should incline upward rather than downward; consequently, if the double lithotome is used, its concavity should be turned toward the symphysis. The extraction of the stone requires no additional description.

Vesico-vaginal Lithotomy. The patient may be placed in the usual lithotomy position, or upon the side, or upon

FIG. 290



SIMS'S SPECULUM

the face. A Sims's speculum (Fig. 290) is pressed against the posterior wall of the vagina, and a grooved catheter in-

introduced into the bladder and confided to an assistant, who keeps it pressed well against the vesico-vaginal septum.

Guiding his knife upon the groove the surgeon makes an antero-posterior incision in the median line of the anterior wall of the vagina, about one inch in length, and not involving the neck of the bladder, passes in his index-finger, and then the forceps upon the finger as a guide.

Emmet places no sutures, but allows the wound to close spontaneously, keeping the bladder clean by frequent washings. Guyon closes the incision immediately with sutures.

In a discussion in the *Société de Chirurgie*¹ the fact was brought out that lithotomy and lithotripsy upon the female are more dangerous operations than they are usually said to be. The fatal complications are of two kinds: peritonitis in patients who have previously been affected by it; and pyæmia, originating in inflammation of the spongio vascular tissue constituting part of the vesico-vaginal septum. Speaking generally, it may be said that lithotripsy² is more dangerous in the female than lithotomy, that the supra-pubic operation should be used for large calculi, dilatation of the urethra for small ones, and, with crushing, for large friable ones when the inflammation is not high and there has been no previous peritonitis; urethral or vesico-vaginal lithotomy in other cases. As to the comparative merits of urethral and vesico-vaginal lithotomy opinions are divided; the former is followed occasionally by permanent incontinence; the latter by fistula; probably, too, the latter is somewhat more dangerous than the former.

OCCCLUSION, OR ATRESIA VAGINÆ.

When the occlusion is due simply to an imperforate hymen it may be relieved by successive punctures with a small trocar or aspirator, and when all the accumulated menstrual blood has been thus removed, and the cavity

¹ Bull. de la Société de Chirurgie, 1877, pp. 182 and 1406.

² In this remark reference is made to the old operation of lithotripsy. The few cases of lithomaxy in the female of which I have knowledge have been successful.

well washed out with a two or three per cent. solution of carbolic acid, the hymen may be excised, or a large puncture made, and kept open by frequently passing a sound. It must be remembered that very serious complications, such as peritonitis and septic poisoning, may follow this simple operation when there has been a large accumulation of menstrual blood above the obstruction.

When, on the other hand, the occlusion is due to incomplete development of the vagina, a more systematic operation is required. The surgeon first assures himself by digital examination through the rectum of the existence of the uterus, then places the patient upon her back with her thighs flexed and abducted, and introduces a sound into the bladder and confides it to an assistant. He next passes his left index-finger into the rectum, makes a transverse incision across the centre of the obliteration, and carries it in the direction of the uterus by successive short cuts with the knife, or by tearing with a director or his fingers, guiding his course by the sound in the bladder and the finger in the rectum. As soon as fluctuation can be felt in front of the uterus he punctures with a trocar and enlarges the puncture with a probe-pointed bistoury.

PERINEORRAPHY.

Dr. Emmet¹ has shown that the lesion previously known as "partial rupture of the perineum," and supposed to be a laceration along the posterior median line of the tissues at the lower part of the vagina and perineum, is actually a transverse rent at or within the ostium vaginæ, which, by the dropping and eversion of the lower lip of the wound, is made to present the appearance of a longitudinal one. He has also recently recognized and described a variety of this lesion in which the laceration is submucous, in which the muscular and fascial diaphragm, constituted in part by the sphincters and closing the outlet of the pelvis, is torn away from the supporting fasciæ and muscles which run upward to attach its centre to the inner side of the bony pelvis,

¹ Principles and Practice of Gynaecology, 1884, p. 354.

and, having thus lost its support, allows the posterior part of the vulva to be everted, with production of a rectocele by protrusion of the rectum through the (subcutaneous) gap. To this latter condition he gives the name *prolapse of the posterior wall of the vagina*. The two conditions, the subcutaneous and the complete rents, are essentially the same, and require nearly the same denudation of the surface. The aim of the operator in either case is to lift up the depressed and everted lower lip, unite its edge to that of the mucous membrane of the vagina at the crest of the rectocele, and thus cover in the latter and renew its anterior support.

Laceration of the vulvar orifice in the posterior median line may occur without coexistence of the above-described lesion, beginning at the fourchette and extending backward, but such laceration is unimportant because it involves only parts that lie outside the real support of the viscera.

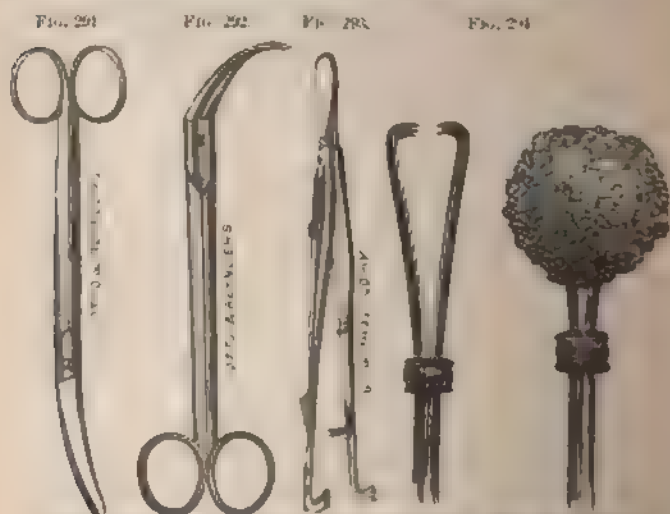


Fig. 291. Curved scissors. Fig. 292. Emmet's toothed forceps. Fig. 293. Thomas's sponge holder. Fig. 294. Sponge holder.

A third form is the important one in which laceration of the sphincter and in the median line takes place. In non-

instrumental delivery this begins as a longitudinal slit in the recto-vaginal septum and extends from within outward and forward. When caused by the forceps it begins at the fourchette and extends backward. To this form Dr. Emmet limits the term *rupture of the perineum*.

Accepting this classification, I shall describe the operation for, 1st, prolapse of the posterior wall of the vagina—two varieties, with and without laceration of the mucous membrane of the vagina; and, 2d, rupture of the perineum (and the sphincter ani).

Prolapse of the Posterior Wall of the Vagina. (1st variety, without surface laceration.) *Operation.* Thighs flexed on abdomen and supported under the arm of an assistant on each side, who also draw aside the labia and hold the tenacula during the act of denudation. The operator seizes with a tenaculum the mucous membrane of the vagina at the crest of the rectocele in the median line at a point which can be drawn down to the urethral orifice by gentle traction, and having thus drawn it down, has it held in place by the assistant. Then, with two other tenacula, he hooks up the lowest caruncle, or vestige of the hymen, on each side, and draws them upward and outward to the first tenaculum. This movement creates an inverted, crescentic, transverse fold within the vagina just below the first tenaculum, its horns shading gradually into the sulcus on each side, and a shallow longitudinal fold in the median line between the last two tenacula. The opposed surfaces of these folds constitute the area to be denuded.

Dropping one lateral tenaculum, he gives the other to an assistant who draws it gently outward to define by this traction the limits of the denudation on that side, and then the surgeon denudes by catching up the mucous membrane with a hook or pronged forceps and removing it with scissors in successive strips. The process is then repeated on the opposite side. Care must be taken not to denude too high on the posterior wall.

Silver sutures are then passed to unite the parts in the positions given them by the first approximation of the three tenacula, producing the line of union indicated in Fig. 295. The sutures of the crescentic part should be of silver wire.

those of the central line may be of silver, silk, or catgut. A final silver suture should be passed through the labium near the caruncle on one side, across to the posterior wall of the vagina, under its mucous membrane for nearly an

FIG. 255.

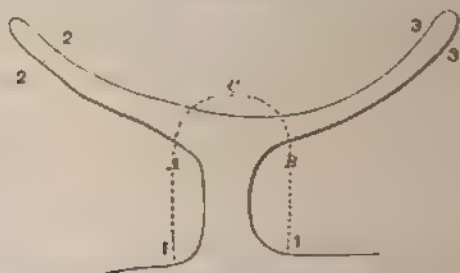


Diagram showing the line of union and direction of the sutures.

inch just above the edge of the denudation, and then through the other labium at a point opposite to that at which it began.

FIG. 256.



Appearance at completion of operation.

In passing the sutures a thick, straight sewing-needle armed with silk should be used, and the tissues to be tra

versed by it should be pressed forward by the finger in the rectum. The sutures should not be buried throughout their course, but should cross the fold midway between its

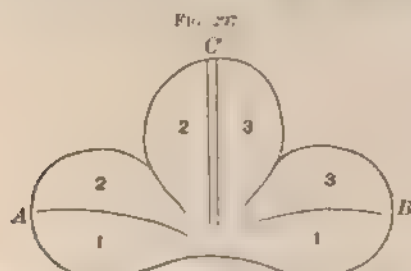
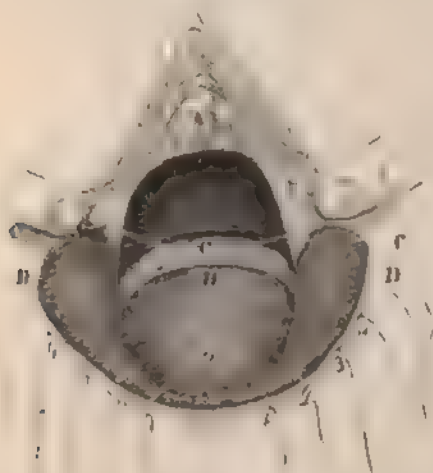


Diagram showing area of denudation. The parts bearing corresponding figures are brought into apposition by the sutures.

FIG. 298.



Emmet's operation for diminishing the vaginal outlet by external sutures.

free edge and its bottom. The silver wire is drawn through in the loop of the silk. The appearance, when the operation is completed, is shown in Fig. 296, the crescentic part being hidden within the vagina.

2d Variety. Prolapse with Surface Laceration. The position of the patient is the same as in the preceding form, and the area of denudation is determined in like manner; speaking generally, it must extend downward to the line of junction between the skin and the cicatricial mucous membrane. Its shape, when spread out, is that of a trefoil (Fig. 297). The sutures are passed in order from below upward, and none tightened till all are in place. The lower ones are buried throughout their course; the upper ones are partly exposed on each side, as shown in Fig. 298. The suture marked *D* includes about an inch of the recto-vaginal septum; the uppermost suture, *C*, passes through the mucous membrane of the septum above the denudation, and when tightened draws it down like a hood to protect the approximated edges, and also sustains all the traction while the opposed denuded surfaces are uniting.

Dr. Emmet leaves the sutures in place for about three weeks.

PERINEORRAPHY.

Method of Hegar or Simon-Hegar. Incomplete Rupture. This is based on the principle that the rent when spread out has the form of a triangle with its apex in the posterior vaginal wall. (Fig. 299.) After every antiseptic precaution, bullet forceps are hooked in the three following points: in the crest of the rectocele, in the posterior vaginal wall, and in the opposite lowest caruncles, which lie on the inner surface of each labium majus. The labia are held apart and traction is made on the forceps, thus putting the tissues between them on the stretch, while a narrow strip of mucous membrane is removed on the lines made straight by traction, which join the crest of the rectocele with the two caruncles in the grasp of the forceps. The space between these limits is rapidly denuded, and the denudation is continued on the posterior vaginal wall and adjacent skin as far as the cicatricial tissue extends, so that the raw surface when flattened out has the form of a triangle with its apex in the rectocele, and its base, which is slightly convex toward the anus, between the two lower forceps on the inner surfaces of the labia majora.

Starting at the apex (Fig. 299), at intervals of about three-eighths of an inch, sutures of silver wire or silk-worm-gut are passed on a well-curved needle, so as to be just buried under the denuded surface, emerging about a quarter of an inch from its edge.

FIG. 299



Incomplete rupture of the perineum. Perineorrhaphy by Simon's method (Pozzi.)

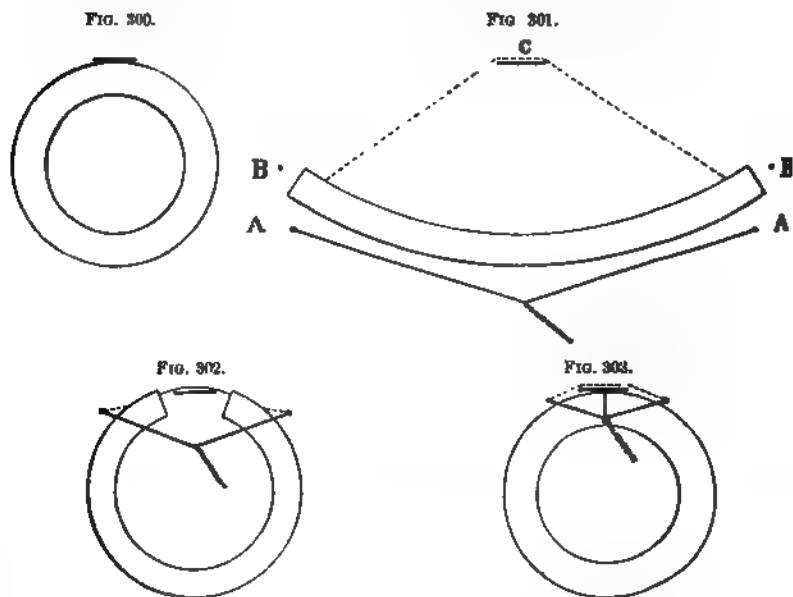
At least two of these sutures should pass deeply enough in the upper lateral portions of the raw area to grasp some of the fibres of the levator ani muscle.

Martin's continuous circular suture applied in tiers is considered better by many surgeons than the interrupted suture. Catgut is used, threaded on a sharply curved needle.

Laceration of the Perineum, including the Sphincter Ani.
If the anterior wall of the rectum is ruptured for more

than one or one and a half inches above the upper margin of the sphincter, Dr. Thomas prefers to close it by a preliminary operation, leaving the restoration of the perineum for a subsequent one. Dr. T. Addis Emmet was the first to show why it is not sufficient simply to close the gap between the vagina and rectum, and to demonstrate the need of bringing the ends of the severed sphincter into close contact with each other, and with the end of the recto-vaginal septum.

Let Fig. 300 represent the perfect sphincter, and Fig. 301 the sphincter ruptured and spread out with the points



of entrance and exit of needle *AA*, the dotted line showing the course of the suture, including the end of the recto-vaginal wall *C*. As the suture is twisted, the three points are brought nearer together, as in Fig. 302, until they finally unite, as in Fig. 303. If the first needle is passed in and out at *BB*, complete union of the ends of the muscle will not be obtained, and loss of function will persist. The

first suture is the important one, and must bring the torn ends of the muscle into contact with each other and with the end of the septum.

In freshening the parts before passing the needles the two lateral triangles, forming the ruptured surface of the body of the perineum, are denuded, and the line of denudation is prolonged backward along the edge of the recto-vaginal septum. This denudation must extend along the edge of the mucous membrane of the rectum, but not include it. Fig. 304 is a schematic representation of the end of the

FIG. 304.



Ruptured sphincter First suture

FIG. 305.



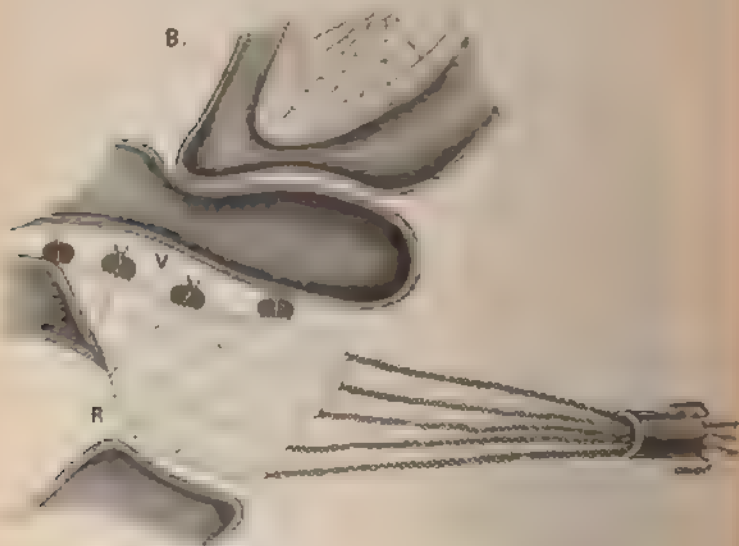
Complete perineal rupture First and second sutures in place.

ruptured bowel, the points of entrance and emergence of the needle, and the course of the first suture.

The rule for passing the first suture, then, is to enter the needle as low down as the lower edge of the anus, pass it

thence upward through the recto-vaginal septum, completely encircling the rent, and bring it out alongside the lower edge of the anus on the other side. Its action, then, is like that of a purse string, it puckers up the open parts, controls the action of the sphincter, and guards against the two principal sources of failure, recto-vaginal fistula and non-union of the sphincter (Fig. 305).

FIG. 305



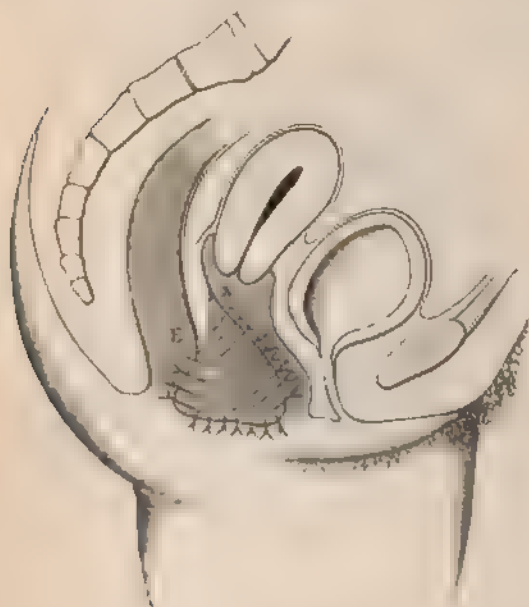
Half section through the pubes

Dr. Emmet now recommends that this injury should be treated as if it were "a recto-vaginal fistula in the median line, with the sides easily approximated."

The denudation is done with scissors, beginning at the outlet and near the rectal surface, and continuing from below upward, so as to avoid the flow of blood over the surface yet to be freshened. Since the sides of the tear, after retraction, are not sufficiently broad to give a good surface for union, a portion of the adjoining vaginal mucous membrane

must be removed, and the angle must also be extended on the vaginal surface for half an inch or more beyond the rectal edge. Then, beginning at the angle, several transverse, interrupted silver sutures are passed from the vaginal edge on one side, under the denuded surface, across the gap, and under the opposite denuded surface to the opposite vaginal edge, and two or three additional sutures are passed

FIG. 307

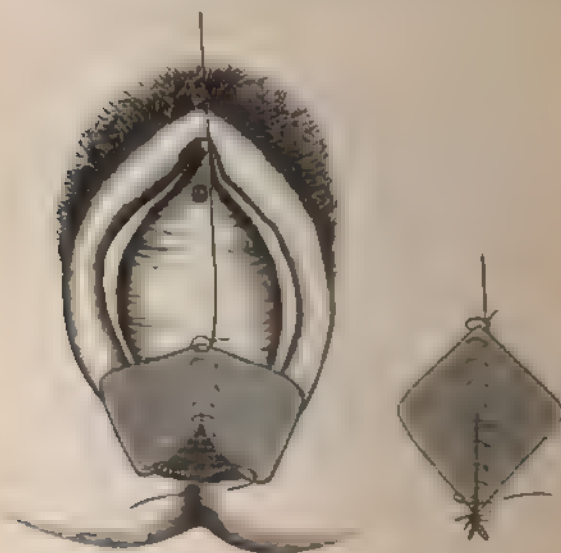


Complete laceration of the perineum. Perineorrhaphy (Simon Hegar method).
general disposition of the sutures. (Figs. 307, 308, 309, 310, 311)

by the old method, that is, beginning in the skin near the lower edge of the anus, continuing up through the tissues alongside the rent, through the septum, and down on the other side, so as completely to include the rent. Fig. 308 shows these different sutures. The last two mentioned are the 2d and 4th in the figure, counting from below upward.

Complete Laceration with Rupture of the Sphincter Ani. A slight modification of Hegar's method is used in the gynecological service of Roosevelt Hospital, and it gives most excellent results. Before denuding the perineum the rectum is first sutured. The edges of the rent in the rectum are freshened and the raw surface is made a little broader below than above to thoroughly expose the extremities of

FIG. 306.



A Complete laceration of the perineum. Perineorrhaphy Mactier's method.
 A Deep plan of continuous suture.
 B Passage from the deep to the superficial. Pozzi.

the sphincter muscle. The denuded areas of muscular and mucous tissue are then brought into apposition by interrupted sutures of chromicized catgut or silk worm-gut passed just within the limits of denudation at intervals of about a quarter of an inch and knotted in the rectum from above downward (Fig. 307). The ends are left long and protruding from the anus, and at the expiration of a couple of weeks

those sutures which can be reached are removed and the ends of the others are cut short and the sutures are left to cut their way out.

The rest of the operation is then finished by Hegar's method for incomplete rupture with Martin's continuous sutures of catgut placed in tiers from the bottom of the rent just external to the rectal wall up to the original level of the vaginal mucous membrane (Fig. 308). A tension suture of silk should be passed through the skin of the perineum, without entering the rectum, a little beyond the extremities of the freshly united sphincter and the ends of the suture fastened over lead buttons or balls, which will permit it to be loosened if there is much subsequent swelling or edema.

VESICO-VAGINAL FISTULA.

The patient is prepared for the operation by measures directed to the improvement of her general condition, by regularly syringing the vagina with warm water, and by dividing any cicatricial bands that may have formed in it.

Position. Dr. Thomas recommends the position known as Sims's. The patient is placed upon the left side, with the thighs flexed, the right rather more so than the left, the left arm is drawn behind her back, and her chest brought flat down upon the table. Others prefer the knee-elbow position, and Simon placed the patient flat upon her back, raised the hips, and flexed the thighs as far as possible upon the abdomen.

FIG. 308.



a Vesical surface b Vaginal surface cc Line of suture

If the first position is employed, an assistant stands behind the patient, draws the posterior wall of the vagina back by means of a broad Sims's speculum held in his right hand, while with his left he raises the right side of the nates.

The surgeon then pinches up, with toothed forceps or a tenaculum, the vaginal edge of the fistula at the point most difficult of access, and cuts off a piece including in breadth

FIG. 30



Drawing down the uterus to facilitate the passing.

all between the vesical edge of the fistula and a point in the vagina at least one-third of an inch from the vaginal edge of the fistula. The cutting may be done with curved scissors

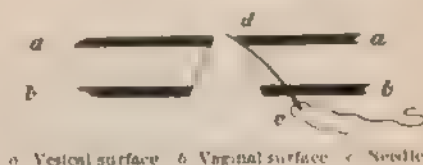
or a narrow-bladed knife. Successive portions of the edge are raised and removed in like manner, until the denudation is complete, the resulting raw surface being funnel-shaped, with its narrowest part at the edge of the vesical mucous

FIG. 311.



Needle-holder

FIG. 312.



a Vesical surface b Vaginal surface c Needle

FIG. 313.



Passing the needle

membrane, the membrane itself not being included in it (Fig. 309). Or the point of the knife may be entered into the mucous membrane of the vagina one-third of an inch from the edge of the fistula, brought out at the vesical

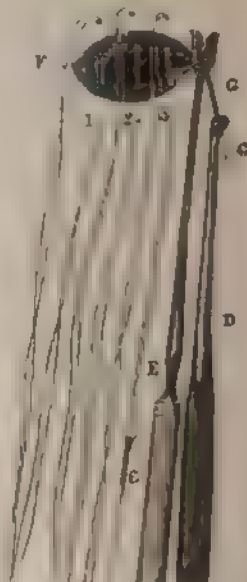
border, and then carried right and left around the opening so as to cut off a complete ring of tissue.

If the anterior wall of the vagina is freely movable, Simon brings the fistula into plain view by passing a stout ligature through the cervix of the uterus and drawing it down toward the vulva (Fig. 310). He also pares the edges of the fistula very freely, and does not hesitate to include the mucous membrane of the bladder in the incision.

FIG. 314 315, 316



FIG. 317.



As soon as the hemorrhage has ceased, the sutures may be passed. The needle, three-quarters of an inch long, round, slightly curved, and armed with a fine double silk suture, is fixed in a needle-holder (Fig. 311), and entered at the angle of the wound which is most difficult of access, half an inch from the edge of the raw surface, and its point brought out at the edge of the vesical mucous membrane, but not including it (Fig. 312), and there fixed with a blunt

hook (Fig. 316), until it can be seized and drawn through with the needle forceps. It is then entered at the corresponding point on the opposite side, and brought out on the

FIG. 314



Simon's method of placing the sutures.

vaginal surface half an inch from the edge of the opening (Fig. 313). The ends of the ligature are given into the charge of the assistant who holds the speculum, and another

needle is passed in the same manner at the distance of one-sixth of an inch from the first : and so on, until a sufficient number have been passed. During the passing of the needles the sides of the fistula are fixed by the tenaculum.

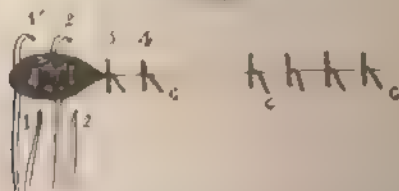
When the needle is seized with forceps and pulled through, counter-pressure must be made upon the tissues, and this is best done by means of the split rod or fork, represented in Fig. 315, its prongs passing on either side of the needle.

After all the ligatures have been passed, a silver wire, about twelve inches long, is fastened to the loop of the first ligature (Fig. 317, *C*), and drawn through with the help of the fork. The silk is cut off, the ends of the wire drawn aside out of the way, and the others passed in the same manner.

Simon used fine silk sutures (two rows when the fistula was large) tied in the ordinary manner, and often passing through the vesical mucous membrane (Fig. 318).

The ends of the silver sutures being drawn together, and the edges of the wound carefully approximated, each thread is slightly twisted so as to keep the parts in apposition, and then the ends of the first are seized with forceps and twisted with the help of the shield (Fig. 314), as shown in Fig. 317; care being taken not to twist so tightly as to strangle the tissues engaged in the loop. The other sutures are then twisted in the same manner, and the ends of each cut off about half an inch from the surface (Fig. 319).

FIG. 319



The bladder is then syringed to remove any blood that may have collected in it, and a Sims's catheter (Fig. 320) passed into it and left there.

The sutures may be removed during the second week.

Creation of a Vesico-vaginal Fistula. This operation is sometimes required in the treatment of chronic cystitis. Dr. Emmet¹ performs it as follows: Anaesthesia; Sims's position. A Sims's speculum is introduced into the vagina, and a director, abruptly curved an inch and a half from its extremity, introduced through the urethra. While the director is held by an assistant with its point firmly pressing in the median line against the base of the bladder a

FIG. 320.



Sims's catheter.

little behind the neck, the surgeon seizes the projecting tissue on the vaginal surface with a tenaculum, and exposes the beak of the director by cutting upon it with a pair of scissors. One of the blades of the scissors is then passed through the opening and a cut made backward in the median line.

If the opening tends to close spontaneously too soon, a hollow glass stud made of half-inch tubing should be buttoned into it. The vesical rim of this stud need not be more than a slight flare, the vaginal rim should be larger.

OBLITERATION OF THE VAGINA; KOLPOKLEISIS.

(Fig. 321.) When a vesico-vaginal fistula cannot be closed by the means above described, the escape of urine may be prevented by closing the vagina. Vidal de Cassis first performed this in 1833 by effecting union between the labia majora, but it has been found that complete closure cannot be thus obtained, a small opening remaining at the lower angle. Simon's method of uniting the anterior and

¹ Chronic Cystitis in the Female, *American Practitioner*, February, 1872, and Vesico-vaginal Fistula, p. 43.

posterior walls of the vagina instead of the labia is much more trustworthy. It was first performed in 1855.

FIG. 321

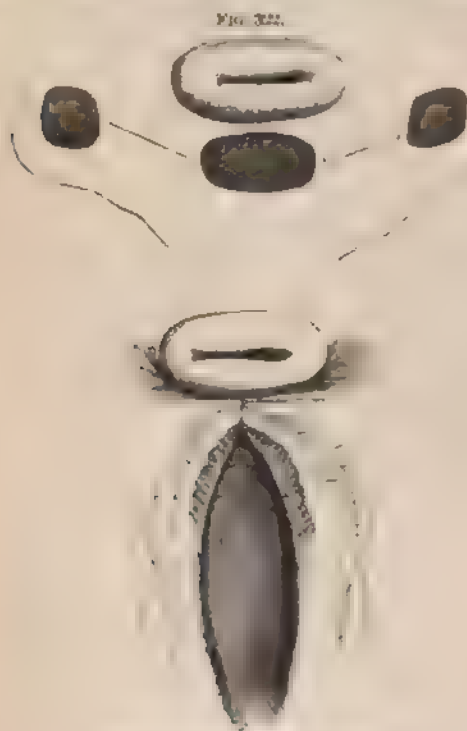


Ostiotomy of the vagina

A strip of mucous membrane encircling the vagina just below the fistula is removed, the opposing raw surfaces brought together by sutures, and the bladder kept empty by a catheter until union has taken place.

ELYTRORRAPHY, OR NARROWING OF THE VAGINA.

This is an operation intended to prevent prolapse of the uterus. The method, introduced by Sims, of removing a longitudinal strip of mucous membrane from each side of the vagina, and bringing the raw surfaces together, has



Emmet's operation for proidentia.

proved not only inefficient, but often actually harmful by supplying a pouch in which the cervix became engaged, thus causing extreme retroversion. Dr. Emmet avoided this defect by closing the pouch at its upper end, but the mechanical difficulties in the way of performing the opera-

tion are so great that he has substituted for it another in which he catches up on a tenaculum three folds of the vaginal mucous membrane, one on each side, and the third in front of the cervix (Fig. 322), denudes them over a space half an inch square, and draws them together with a suture. The three folds radiating from these points are then pared, and united stitch by stitch along the anterior wall of the vagina.

Dr. Thomas suggests a method which, he thinks, promises well. It may be performed upon either vaginal wall, or on both in two successive operations. While doing it, the uterus may be left in complete prolapse, or it may be previously returned to the pelvis.

Suppose an operation on the anterior wall, the uterus prolapsed. Dorsal decubitus. The mucous membrane of the vagina half an inch from one side of the cervix is pinched up, and a small hole made in it through which a grooved director is passed directly across the anterior face of the uterus, between it and the vagina, to the corresponding point on the other side of the cervix. Upon this director the vagina is cut transversely. The director is again entered at the centre of the transverse incision, worked up through the loose areolar tissue between the bladder and vagina nearly to the meatus, and then withdrawn. A steel instrument (Fig. 323), as large as a No. 9 sound, with blades three inches long, is passed along the channel made

FIG. 323



Thomas's separating forceps.

by the director and opened forcibly so as to tear the subcutaneous tissue and separate the bladder from the vagina over a triangular space, the apex of which is near the meatus and the base at the cervix.

The ends of the transverse incision are then brought together by a suture, the result being that the loosened

triangular portion of mucous membrane hangs down and forms a longitudinal fold; this fold is engaged between the blades of a toothed clamp three inches long and half an inch

FIG. 324.



wide (Fig. 324), placed with its hinge at the cervix and tightened by means of the screw. Then the portion of the

FIG. 325.



* otoperineorrhaphy by Hegar's method Pozzi.

vaginal mucous membrane hanging out of the clamp is cut off, the edges of the wound brought together with interrupted silver sutures, and the uterus returned with the clamp still

in place. The vagina is then firmly plugged with cotton wet with a solution of alum and carbolic acid, to prevent hemorrhage; this plug should be removed at the end of twenty-four hours, the clamp after forty-eight hours, and the sutures in eight or nine days.

FIG. 325



Colpo-perineorrhaphy by Martin's method. Bilateral denudation of posterior vaginal wall, continuous sutures in layers. (Bozzani)

For the operation upon the posterior wall of the vagina, or when the uterus is in place, the transverse incision at the cervix should not be made, the dilating forceps being passed in the opposite direction.

Posterior Elytorrhaphy or Obporrhaphy. (Hegar's Method.) The entire thickness of a portion of the mucous membrane is removed from the posterior vaginal wall in the form of an isosceles triangle (Fig. 325), with its base about two inches broad at the fourchette, and its apex in the median line two inches above the fourchette. For very marked prolapse these measurements may be extended a

quarter or half an inch. The denuded area is folded together by the interrupted, or better by Martin's suture as described for perineorrhaphy.

Martin's Method (Fig. 326). Two narrow strips of mucous membrane are removed from the posterior vaginal wall on each side of the median line from just below the cul-de-sac to a finger's breadth above the fourchette.

The operation is completed by perineorrhaphy with Martin's suture throughout.

Anterior. A portion of the entire thickness of the mucous membrane on the anterior vaginal wall is excised in the form of a circle, oval or diamond, measuring generally about an inch or an inch and a half in its longitudinal diameter, and situated about the same distance from the meatus.

The denuded surface is folded together by the interrupted or purse string or Martin's suture.

LACERATED CERVIX.

Dr. Thomas Addis Emmet¹ was the first to point out that after laceration of the cervix the lips rolled out, their mucous membrane became eroded by contact with the floor of the pelvis, and that the proper method of treatment was to freshen the torn surfaces and bring them together with sutures, so as to restore to the cervix its normal size and form. In cases which have long remained unrecognized or untreated, the lips become centrally enlarged by the inflammatory process, so that they cannot be properly brought together until after the removal of a thick piece on each side of the inside of each lip (Figs. 327 and 328). In like manner, when the eversion is increased and the coaptation of the lips prevented by cystic degeneration of the mucous follicles lining the cervical canal, and by vascular engorgement due to the inflammation and to a constriction by the everted edge of the cervix, similar to that observed in paraphimosis, free punctures must be made with the

¹ American Journal of Obstetrics, November, 1874.

point of a knife to let out the blood and the contents of the cysts. It is well to do this several days or weeks before the operation, apply tincture of iodine to the cervix, and bring the lips together temporarily by putting a plug of cotton into the posterior cul-de sac and leaving it there for several hours at a time. The puncturing and application of iodine must be frequently repeated until the cysts shall have all disappeared and the erosions become nearly or entirely healed.

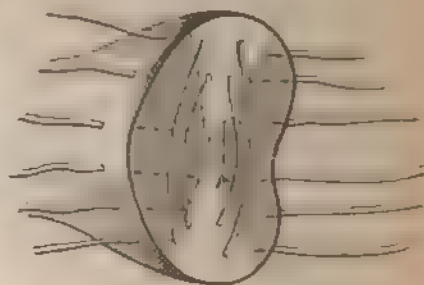
The patient is placed on her left side, a Sims's speculum introduced, and a loop of wire placed around the cervix above the vaginal reflection and tightened by drawing its

FIG. 327.



Lacerated cervix. Side view

FIG. 328.



Lacerated cervix showing denuded surface the shaded parts and sutures.

ends down through a canula so as to prevent bleeding; or an injection of hot water just before the operation will answer the same purpose. The lips are then separated and the lacerated surfaces thoroughly freshened with curved or angular scissors or a knife, leaving a broad undenuded strip in the centre to form the lining of the restored canal. This strip should be shaped somewhat like an hour-glass in order to allow for the shrinking of the cervix which follows the operation (Fig. 328). The freshening should be done from below upward, so that the blood may not interfere, and must be carried deeply enough to remove all diseased glands and follicles.

A tenaculum is then engaged in each lip, and the two

drawn together; if proper coaptation is prevented by the central enlargement of the cervix above mentioned, simple freshening of the surface is not sufficient, but a greater thickness of tissue must be removed. The freshening at the angles of the fissure should be superficial, so as not to involve the circular artery which often lies just at that point.

The sutures should be of silver wire, and passed with a short, round needle if the tissues are soft, or with a lance-shaped one if they are dense and indurated. From three to five will be needed on each side if the laceration is extensive and double. The first one on each side should be entered just beyond the angle of the fissure so as to include the branches of the circular artery if necessary. The needle is entered on the outside of the lip and brought out at the edge of the undenuded strip which is to form the canal, and then passed in the opposite direction (from within outward) at corresponding points through the other lip. Care must be taken to obtain accurate approximation along the vaginal edge, but the inner edges of the denuded surfaces do not require attention.

POSTERIOR SECTION OF THE CERVIX.

This operation may be rendered necessary by irreducible flexion of the uterus. The patient being placed in position

FIG. 329.



Sims's knife.

and a Sims's speculum introduced, the cervix is fixed by a tenaculum and its posterior lip divided with scissors as high as to the vaginal junction. The blade of a Sims's knife (Fig. 329) is then introduced through the os internum, and the tissues cut so as to lay open the posterior wall of the

cervix (Fig. 330). The blade is then turned toward the anterior wall, and the little shoulder which, as Dr. Emmet has pointed out, usually exists there at the point of flexion is cut through. Instead of making this second incision Dr. Wylie practises and recommends divulsion with a strong steel dilator.

FIG. 330



Posterior section of the cervix.

A roll of cotton saturated with a solution of persulphate of iron, one part to two of water, is placed so as to occupy the whole cervix, and retained by a plug of wet cotton in the vagina.

OPERATIONS ON THE UTERUS AND ADNEXA.

Anatomy. The broad ligaments, consisting of two layers of peritoneum, continuous with that which covers the uterus, are attached to its sides from the cornua to the level of the internal os; externally they are attached to the sides of the pelvis in a vertical but broader line, about midway between the obturator foramen and the great sciatic notch. The Fallopian tube passes outward from the angle of the uterus in the highest part of the broad ligament, while in front

and a little lower down the round ligament diverges to the internal abdominal ring, and contains a branch of the epigastric artery passing to the uterus. Behind the Fallopian tubes are the ovaries which are subject to great variation in position—normally each occupies the apex of a ligamentous triangle directed backward, the base of which is in the broad ligament, and through which the branches of the ovarian artery and the pampiniform plexus of veins enter the gland. The inner angle of the ligamentous triangle passing to the fundus of the uterus is a rounded fold of peritoneum containing muscular fibre, and called the utero-ovarian ligament. The outer angle blends with the upper border of the broad ligament, and is called the infundibulo-pelvic ligament.

The ovarian arteries arise from the abdominal aorta, and at the brim of the pelvis cross the bifurcation of the common iliac vessels and the ureter, and run in a tortuous course in the upper border of the broad ligament, or more exactly in the infundibulo-pelvic ligament, to the cornua of the uterus, where they anastomose with the uterine arteries along the respective sides.

Each ureter crosses the common iliac artery near its bifurcation, and runs from behind downward, forward, and inward in front of the internal iliac artery and its anterior division, lying in the base of the broad ligament, which is limited by the levator ani muscle. Near the level of the external os the ureter is crossed on its inner side by the uterine artery, and then runs along the side of the vagina about half an inch from the cervix, entering the bladder just above the middle of the anterior vaginal wall. The uterine artery arises from the anterior trunk of the internal iliac near the synchondrosis, and passes downward and forward to a point just above the spine of the ischium, where it leaves the pelvic wall, but still descends almost to the tuberosity of the ischium; it then turns up toward the vagina, reaching the uterus at the utero-vaginal junction. Opposite the external os it gives off the circular artery of the cervix and continues along the side of the uterus between the layers of the broad ligament, and at the superior cornu it anastomoses with the ovarian artery.

The peritoneum is firmly adherent to the fundus of the

uterus, but gradually becomes more loosely attached until it can be readily stripped up with the finger in the vesicouterine depression. Posteriorly it descends about three-quarters of an inch on the vaginal wall, and is likewise easily peeled off to the same level as in front. With a normal uterus and an empty bladder, the latter lies upon the cervix for about half an inch.

OVARIOTOMY

The patient is prepared in the usual way for a laparotomy, and immediately before the operation she is catheterized, the sponges, pads, and clamps are counted and the number of each written down. An incision three or four inches long is made in the median line between the umbilicus and the pubes, which, if necessary, is later extended upward with a slight semicircular deviation, including the umbilicus and passing to the left of it to avoid the falciform ligament. The incision is deepened layer by layer and the peritoneum first opened above by pinching up a fold with the fingers or forceps and nicking it, and then enlarging it downward by cutting on the fingers inside as a director, care being taken to avoid the bladder, which is usually recognizable from within as a thickened fold lying near the pubes.

When the peritoneum is adherent to the tumor it may be simpler to prolong the incision above the latter to make certain that the abdominal cavity has been opened and that the peritoneum is not simply stripped from the parietes. Sometimes, also, the bladder is drawn far up above its usual position, but it can be recognized by its vascularity or by a sound passed into it through the urethra. A sponge protective packing is wedged around the exposed cyst, which is then punctured with a large trocar and cannula, the latter being provided with a tube to conduct the fluid to one side, and as soon as possible the walls are grasped by the fingers or by forceps and drawn into the wound, while, at the same time, pressure is made on the parietes, or the patient is rolled on one side to favor the escape of the contents. If the latter are too thick to flow readily, the puncture may have to be enlarged sufficiently

to permit them to be scooped out by hand, and through this opening other loculi are entered by the finger, knife, or trocar, and enough liquid evacuated to permit of an attempt to turn the cyst out of the abdomen.

The adhesions are cautiously separated by the finger-nail and blunt-pointed scissors or divided between double catgut ligatures; if the intestine is torn the rent must be immediately closed by Lembert's sutures.

The peritoneal cavity must be constantly protected by the addition of fresh sponges as the dissection progresses, though usually no harm follows from the escape into it of some of the cyst-contents. When the pedicle has been fully exposed, often by bringing the cyst out of the belly, if broad it is secured in sections by the interlocking silk ligature passed on a blunt-pointed aneurism needle, and the tumor or what remains of it is excised; or the pedicle may be divided with scissors and the vessels secured as they are encountered by clamps, and after removal of the tumor ligated separately.

A comparatively small pedicle can be ligated *en masse* with stout silk, or by the Staffordshire knot, in which the pedicle is transfixed by a stout silk ligature passed double and the loop drawn back over the tumor to lie between the long ends of the ligature, which are then tied over it.

If there have been few or no adhesions and the cyst has been removed practically without opening it, the abdominal wound can be closed entirely in the usual way, after taking out and counting the sponges and clamps. But drainage by rubber tubes and iodoform-gauze packing is imperative whenever there is even a possibility of infection, and especially if a portion of the cyst wall has been necessarily left behind owing to its too firm adhesion to important structures. If there has been much peritoneal laceration accompanied by oozing from minute blood-vessels, drainage and hemostasis are conveniently provided for by a large sheet of iodoform gauze placed in contact with the lacerated surface and having all its edges brought out of the abdominal wound.

This pouch is then stuffed with strips of gauze which are subsequently removed one by one, to gradually reduce

its bulk. The parietal opening is partially closed and dressed antiseptically in the usual way.

OÖPHORECTOMY.

This term is used to designate the removal of macroscopically normal ovaries and Fallopian tubes for hemostatic or analgesic purposes.

After the usual preliminaries, including catheterization, the patient is placed in Trendelenburg's position, which greatly facilitates all intra-abdominal operations on the pelvic organs.

A convenient extemporaneous way of doing this is to invert a chair upon the table and lay the patient upon its back so that her knees are hooked over the cross bars between its hind legs.

An incision about three inches long is made in the median line above the pubes, and deepened layer by layer till the peritoneal cavity is opened. Two fingers are passed through the incision to the fundus of the uterus and thence outward, following one Fallopian tube to its extremity, which is drawn up into the abdominal wound together with the ovary. Flat sponges are placed around them, and a stout silk ligature is passed double on a blunt-pointed aneurism needle through the broad ligament in the angle between the Fallopian tube and the uterus, and the Staffordshire knot is made and tied as close to the uterus as possible, with care to get beyond the ovary and not leave any portion of the gland in its grasp. The ovary and tube are then excised, and after a final inspection of the pouch for hemorrhage it is dropped back into the abdomen.

The same proceeding is repeated upon the other side, the flat sponges are removed, and finally the abdominal incision is closed tight in the usual way and dressed without drainage.

SALPINGO-OOPHORECTOMY, OR THE REMOVAL OF A TUBE DISTENDED WITH PUS, AND ITS OVARY.

After the usual preliminaries, including antiseptic vaginal douches, the patient is catheterized and placed in Trendelenburg's position, as described for oöphorectomy, and if, at the same time, a bougie is inserted in the rectum, it may later be found very useful for mapping out its position. An incision not less than four inches long is made in the median line above the pubes, afterward extended, if necessary, around the umbilicus to afford plenty of room for manipulation. The incision is deepened layer by layer, the bleeding stopped, and the peritoneum nicked in the upper angle of the wound and opened downward on the finger as a guide, stopping short of the bladder, which can be recognized on the inside as a thickened fold near the pubes; or, if there is any doubt, by a sound passed through the urethra. The omentum and intestines are pushed back, separating adhesions with the finger-nail or blunt-pointed scissors, till there is a full exposure of the uterus and its appendages, which are then surrounded with flat sponges or pads, completely shutting off the rest of the peritoneal cavity.

The fingers are passed outward from the fundus of the uterus, following every crevice around first one tube and then the other, till some spot is found where, by slight pressure or tearing, the tip of the index-finger can be worked under or around the mass and the tube freed, generally in company with its ovary. If pus should be discovered escaping, the dissection is stopped till it has been entirely sponged away, enlarging, if necessary, the hole from which it comes. The somewhat free oozing is controlled by sponge packing, and when a more or less distinct pedicle has been formed, or the finger recognizes a dangerous amount of resistance to its progress, the stripping up and gently tearing process is stopped.

With a blunt-pointed aneurism needle a stout catgut ligature is then passed under the infundibulo-pelvic ligament, or the outer attachment of the freed mass consisting of the ovary and diseased tube, tying off this ligament

close to the mass and including the ovarian artery, the position of which can be ascertained in advance by palpating the broad ligament and noting the pulsation.

Another catgut ligature is passed through the broad ligament in the angle formed by the junction of the uterus and Fallopian tube, and the latter is secured with the termination of the artery close to the uterus.

Beginning on the uterine side of the outer ligature, the tissues attached to the under side of the tube are cut with blunt-pointed scissors, clamping each vessel or bleeding point as it is encountered, and in this way, when the tube alone is diseased, it is generally easy to leave the ovary undisturbed, and this is always done by some surgeons; but in such an instance there should be no preliminary ligature of the infundibulo-pelvic ligament with the ovarian artery, and the scissors must be kept close to the tube, while bleeding is controlled by individual ligature of each vessel as it is cut.

The diseased mass is then excised on the distal side of the ligature next to the uterus and the stump disinfected. Before its division the tube is secured by a clamp to prevent the escape of pus if it has not already occurred.

Ligature *en masse* of the pedicle, which is almost always bulky, is only mentioned to be condemned. After changing the sponges and securing any vessels which still bleed, the cut edges of peritoneum forming the broad ligament are united with fine catgut sutures over the denuded area which lies under the Fallopian tube, and when it has been possible to perform the operation without the escape of a drop of pus, and without leaving a large oozing surface, the protective sponges are removed and the abdominal wound closed tight in the usual way.

Otherwise the peritoneal cavity is made as clean and dry as possible and rubber tubes with lateral perforations are placed in the suspected regions, with one always in Douglas's pouch, and surrounded by strips of iodoform gauze, around the ends of which the abdominal wound is partially closed.

Sometimes the Fallopian tube will be found changed into an abscess sac, with very firm adhesions, which only permit the sac to be opened, or not more than partially

removed; very rarely it can be only partially exposed, but the pus can always be reached somewhere by a careful dissection, aided possibly by a guiding puncture with an aspirating needle. The surrounding parts are then carefully protected by a sponge packing and the abscess cavity thoroughly evacuated and washed out with boiled water, and drained with rubber tubes and iodoform gauze. Communication between the abdominal wound and the opening in the sac, which may be at a distance from the surface, is maintained by packing, which should also extend into and protect all possibly infected regions around the abscess. Aided by an exploring finger in the vagina it will sometimes be possible and very advisable to force a blunt pointed forceps from the bottom of the abscess cavity into the posterior fornix, and thus pass a tube to afford drainage in the most dependent regions as well as from the surface of the abdomen. The vagina is packed around the tube and a dressing is placed on the vulva, while every precaution is taken to prevent infection from the urine and feces.

If the vermiform appendix is found involved or adherent to a diseased tube, as often happens, it should be excised at the same time. Whenever in a case in which the abdominal wound has been closed tight symptoms of secondary hemorrhage appear, the diagnosis should be at once verified by untying a stitch in the lower angle of the wound and passing a small sponge on a holder into Douglas's pouch. If done with every antiseptic precaution this exploration is free from danger, even if no hemorrhage is found.

TUMORS LYING BENEATH THE BROAD LIGAMENT.

An opening is made in the overlying peritoneum generally in front of the Fallopian tube, and through this the dissection, guided by the sense of touch, is carried out by the tip of the finger tearing through the loose connective tissue surrounding the capsule of the tumor, and the latter enucleated. The few vessels are clamped as they are encountered and tied later, and drainage is provided for as after salpingo-oophorectomy.

OPERATIONS FOR ECTOPIC GESTATION.

In the early stages of this condition before the placenta has formed, the operation is conducted, according to the situation of the mass, in the same way as in ovariectomy or salpingo-oöphorectomy, or for a tumor lying below the broad ligament.

Later, after the formation of the placenta, the general rule is to open the abdomen in the median line below the umbilicus, and, after protecting the peritoneal cavity by a sponge packing, the sac is entered in front like an ovarian cyst, avoiding if possible the site of the placenta, which can usually be recognized by the surrounding vascularity. But sometimes the placenta may have to be perforated, and then the hemorrhage from it is controlled by clamps or deep sutures.

The fetus and amniotic liquid are extracted while the surrounding parts are well guarded, and when it seems perfectly feasible the sac may be dissected out with the placenta, separating adhesions with the tip of the finger or blunt-pointed scissors and arresting the bleeding as it occurs; but more often the complete removal is impossible, and the opening in the sac is either stitched to the margins of the abdominal wound or kept in communication with it by packing and drainage applied on the principles already enunciated, while the placenta is left to slough away with the attached umbilical cord.

If the operation is performed for hemorrhage following rupture of an extra-uterine gestation, the abdomen is opened in the same way and one hand passed to the fundus of the uterus and thence outward to the boggy mass, which, if it can be raised to the surface, is easily secured and treated. But if this is impossible, an attempt, guided by the hand inside the belly, is made to seize one or both extremities of the broad ligament with its contained vessels, by long-bladed clamps.

The blood and *débris* are then rapidly scooped out of the peritoneal cavity and a search is made for bleeding points, which are immediately caught and tied, and then a decision can be made as to extirpation of the sac, which does not

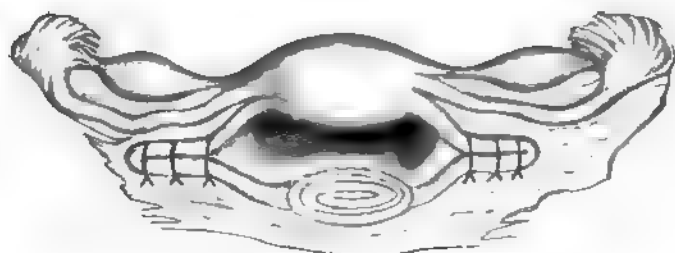
differ from an inherent tube or an ovarian cyst, except that the placenta in the great majority of cases should not be disturbed.

The treatment of a case in which suppuration has occurred does not differ from that of an intra-abdominal or pelvic abscess.

HYSTEROPEXY.

The peritoneal cavity is opened by a median incision of about three inches just above the pubes, and the fundus of the uterus is brought up to the abdominal wall, to which it is fixed by a couple of silk or silkworm-gut sutures passed through all the tissues on each side of the wound, and through the muscular tissue of the fundus of the uterus,

FIG. 331.



Hysteropexy. Wylie's method of shortening the round ligaments.

including about three-quarters of a square inch of the peritoneal coat. Other sutures are placed in the wound above and below, which is thus closed tight without drainage when all are tied.

The fundus of the uterus may be previously scraped or scratched to promote adhesions, and Wylie¹ shortens the round ligaments by throwing a suture around a loop of each in the abdomen (Fig. 331).

¹ Amer. Journ. Obst., 1889, p. 478.

ALEXANDER'S OPERATION¹ FOR SHORTENING THE
ROUND LIGAMENTS.

With every antiseptic precaution an oblique incision an inch and a half or two inches long is made over the inguinal canal terminating near the spine of the pubis. The external abdominal ring is cleared and the intercolumnar fascia is divided, exposing the fine yellow fat in which the reddish cord-like round ligament will be found near the upper limit of the external abdominal ring. The other side is treated in the same manner.

A slight dissection may be necessary to isolate the round ligament, and, aided by a sound in the cavity of the uterus, enough traction is made on the cords to raise the uterus to the desired position. Often four or five inches of the round ligament can thus be easily drawn out through the ring.

The ligaments on each side are held in their new position by a couple of sutures of catgut or silk-worm-gut passed through them and the external and internal pillars of each ring. The wound in the intercolumnar fascia is closed with fine catgut and the external wound is sutured and dressed antiseptically without drainage.

Tampons or pessaries must be worn for a month.

LAPARO-HYSTEROTOMY.

By this term is meant the making of an opening into the cavity of the uterus for any purpose, commonly the extraction of a fetus. In the latter instance the time of election, according to Senn,² is during the first stage of labor.

The patient is catheterized, and with every antiseptic precaution, including preliminary antiseptic douches for the vagina, an incision about six inches long is made in the median line above the pubes, and, bearing in mind that the abdominal wall is apt to be very thin and that the enlarged uterus is in contact with it without the interposition of

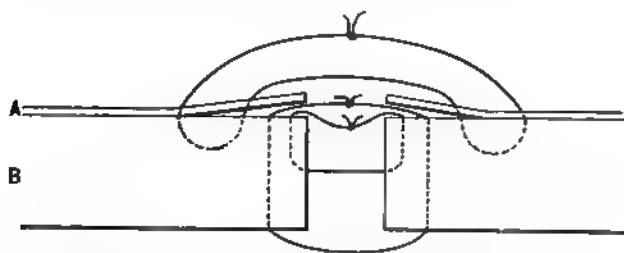
¹ Liverpool Med. Clin. Journ., January, 1893, p. 113.

² Amer. Journ. Med. Sci., Sept., 1893.

other viscera, the incision is cautiously deepened layer by layer till the peritoneal cavity is opened in the whole extent of the wound and the surface of the uterus exposed.

Sponges are packed around the latter and a longitudinal incision about an inch long is made in its anterior wall at a point midway between the junction of the Fallopian tubes with the uterus. To lessen the hemorrhage this incision is enlarged downward by tearing sufficiently to extract the child, head first, which must be done as rapidly as possible after rupturing the membranes. As the bleeding is worst from the cervical region, the rent must not approach this too closely.

FIG. 332.



Closure of the uterine wound after Caesarean section. A. Peritoneum.
B. Muscular wall of the uterus.

The uterus is immediately turned out of the abdomen, which is then protected by a warm towel and its neck below the opening constricted by an elastic ligature secured by a clamp tightly enough to arrest the bleeding. The placenta is next peeled off with its attached membranes, and after cleansing the interior of the uterus the rent is closed by a row of interrupted stout catgut sutures passed at intervals of half an inch through the entire thickness of the uterine wall, exclusive of the peritoneum, and about half an inch from the torn edge.

Another row of sutures is placed between these in the same way, but including only half the muscular thickness, and these are covered in by a row of catgut Lembert sutures, which should pass through enough of the muscular tissue to secure good peritoneal apposition over the line of suture. (Fig. 332.)

The abdominal cavity is cleansed and the elastic ligature removed from the uterus, but the latter is not replaced in the belly until after contraction has occurred or been induced by pressure, rubbing, or the subcutaneous injection of ergot. The abdominal wound is then closed tight in the usual way and dressed without drainage, and an iodoform-gauze packing is placed in the interior of the uterus from the vagina.

SYMPHYSIOTOMY.¹

The patient is catheterized, and, after thorough disinfection of the abdominal wall and the external genitala, a longitudinal incision two or three inches long is made over the symphysis and carried down to the bone.

The origin of one pyramidalis muscle is divided sufficiently to admit the index-finger, which is inserted behind the pubes, separating and pushing back from the bone the prevesical tissues, and on this finger as a guide the symphysis, which usually is not exactly in the middle line, is divided by a probe-pointed cartilage knife from above and behind downward and forward, sparing if possible the ligamentum arcuatum or triangular ligament. A sound is sometimes first placed in the urethra and bladder to draw them to one side.

After extraction of the child, *per vias naturales*, the pubic bones can be reunited by buried silk sutures, or the wound may be closed by silk sutures passed through the skin and the anterior portion of the symphysis. But it will generally be found sufficient to insert simple superficial sutures, and, after dressing the wound antiseptically, to immobilize the pelvis by a stout binder or bandage.

MYOMECTOMY, OR THE REMOVAL OF A SUBPERITONEAL "FIBROID" TUMOR OF THE UTERUS.

The abdomen is opened as usual in the median line below the umbilicus sufficiently to admit the hand, and after

¹ Morisani: *Ann. de Gynec. et d'Obst.*, April, 1892, p. 241. Charpentier: *Bull. de l'Acad. de Med.*, March, 1892, p. 352.

exploration the incision is enlarged if necessary, and adhesions carefully separated or divided between double catgut ligatures. The rest of the peritoneal cavity is shut off by a sponge protective packing, and when the growth has a distinct pedicle the latter is simply surrounded by a silk ligature which may in addition first transfix the pedicle if it is large, and the growth is excised; or, when there is no pedicle and the tumor is sharply defined, two semilunar flaps are cut from the peritoneum on its base, and through the gap thus made the tumor enucleated by the tip of the finger or blunt-pointed scissors.

The vessels, which are principally superficial, are clamped and tied as they are encountered, and if there is bleeding from vessels buried in the base it can be controlled by a deep catgut suture passed on a curved needle.

The peritoneal flaps are closed over the denuded surface with fine catgut, and if it seems advisable after removal of the sponge protectives an iodoform-gauze packing is placed in contact with any region where hemorrhage or infection is possible, and the abdominal wound is partially closed around the ends of the gauze. When all goes well this packing is removed after twenty-four or forty-eight hours, and the wound is then closed tight for secondary union by a stitch inserted for this purpose at the time of the operation.

ABDOMINAL HYSTERECTOMY.

If the uterus is comparatively normal, there is no unusual difficulty about this operation.

After rendering the vagina aseptic, the patient is catheterized and placed in Trendelenburg's position and a median incision about eight inches long is made above the pubes and deepened layer by layer till the abdomen is opened. The intestines are covered and pushed back from the pelvis by flat sponges or pads, and the Fallopian tube and utero-ovarian and round ligaments are secured together on each side close to the uterus by a double ligature of stout catgut passed through the broad ligament under these structures on an aneurism needle. Then the pulsations of

the uterine arteries are felt for at the sides of the cervix, and each artery is ligated near the vault of the vagina by stout catgut passed through an incision in the peritoneum on an aneurism needle, which must be kept as close to the artery as possible. Starting at the cornu, the tissues are divided between the double ligatures, and each broad ligament is cut at the lateral border of the uterus as low as the utero-vesical fold of peritoneum, which is divided transversely by cutting toward the uterus and hugging close to the cervix; with short snips of the scissors the anterior fornix of the vagina is entered.

Posteriorly, the peritoneum is cut transversely at the level of the internal os or a little lower, and the posterior fornix is entered like the anterior and the uterus removed. After tying the bleeding points, which are few, a rubber drainage tube and iodoform-gauze packing are passed from the abdominal wound out through the vagina, leaving the internal extremities in contact with the stumps of the tubes and the opening made in the vagina, and not communicating with the abdominal wound, which is then closed tight in the usual way and dressed without drainage. An antiseptic dressing is placed over the termination of the tube and packing at the vulva, and every precaution taken to prevent infection by the urine or feces.

It may often be desirable to divide the outer instead of the inner end of the broad ligament between a double catgut ligature, and, after securing the uterine artery at the cervix, to free the tubes and ovaries by cutting close beneath them, as formerly described, and then, following the sides of the uterus, to excise the latter, together with the appendages.

If the uterus has become greatly altered by the growth of a tumor, no description can be given which is applicable to all cases. The abdomen is opened by a median incision which may have to be prolonged from the symphysis to the ensiform process, and the limits of the bladder, which is apt to be drawn above its usual position, are ascertained by a sound in the urethra if necessary. Adhesions, which may exist between the tumor and any abdominal viscera, are carefully separated or divided between double catgut ligatures, and the mass is gradually lifted out of the belly

by a hand placed beneath it, ascertaining its connections and the position of the ovaries, tubes, and the broad ligaments, and the cavity is immediately protected by a sponge packing or warm towels.

It may be possible to follow the formal method of removal already given, but otherwise the enlarged uterus is transfixed below by a couple of pins made for the purpose with guarded points, and under these, which prevent it slipping, an elastic tourniquet or *écraseur* is applied, including both broad ligaments, with due regard for the position of the bladder; frequently a smaller pedicle can or must be manufactured, generally by dividing the broad ligaments in sections between double catgut ligatures. The mass distal to the tourniquet is then excised and the cervical canal disinfected by a drop of pure carbolic acid.

If the stump is to be treated extra-peritoneally, it is left in the lower angle of the wound with the tourniquet in place and the pins resting on the surface of the abdomen; the protective packing with blood clots, etc., is removed; and the wound is closed in the usual way around the stump, with care to secure peritoneal apposition, if necessary, by sutures below the ligatures.

Sometimes the pins may have to be withdrawn from the stump and the latter fixed at the level of the parietal peritoneum, where it can be retained by a couple of silk sutures through the abdominal wall on each side of the wound, which is then closed above and below around a packing placed in contact with the stump and its edges.

If the pedicle is to be treated by the intra-peritoneal method, the base of the growth is cut in the form of a cone or triangle with its apex in the cervical canal at the level of the rubber tourniquet, and, after disinfecting the canal and securing the open mouths of any vessels in sight, the peritoneal margins of the stump are united with catgut, the tourniquet removed, and deep catgut sutures placed to arrest whatever bleeding follows. The stump is then dropped back into the abdomen, and the latter cleaned, drawing the peritoneum as far as possible over any exposed raw surfaces, and the parietal wound is closed around drainage carried down to the stump, or it is closed tight without drainage.

It is always advisable, when practicable, to place independent catgut ligatures upon the ovarian arteries. Ligatures *en masse* are so apt to slip, and dangerous hemorrhage is so frequent an accident after their use, that if the condition of the patient permit the attempt should always be made to secure vessels on the cut surface of the pedicle and then remove the ligature *en masse*.

Amputation of the Gravid Uterus. (Porro's Operation.)

In a true Porro's operation the fetus is viable and is extracted before the uterus is excised. The abdomen is opened and the fetus removed as described for laparohysterotomy, except that the longitudinal direction of the uterine incision is of less consequence. In Muller's modification the parietal incision is made sufficiently long to permit the uterus to be turned out of the abdomen before the child is removed.

After tying the cord the uterus is immediately lifted out of the belly and an elastic ligature or écraseur is thrown around the cervix and broad ligaments. The uterus with the ovaries and tubes is then amputated transversely about three-quarters of an inch above the constriction, and the stump is fastened in the lower angle of the wound by a couple of pins transfixing it distal to the ligature and resting on the skin with the points protected. The abdominal cavity is cleansed and the protective sponges are removed and the wound is closed in the usual way around the stump, stitching the edges of the peritoneum with catgut to the uterine peritoneum below the constricting band, though this is not always necessary.

In this, as in similar operations, it is advisable to place two dressings on the wound, the upper to remain undisturbed, while the lower, covering the sloughing pedicle, is changed as often as required.

Vaginal Hysterectomy The patient is catheterized and placed in the lithotomy position and the external genitals are thoroughly disinfected. The vagina is held open by broad retractors and the uterus is pulled down by volsella forceps grasping the cervix, while the adjoining mucous membrane is cut well clear of the disease by blunt-

pointed scissors. Keeping close to the uterus the dissection is continued on its anterior and posterior surface by the tip of the finger and short snips of the scissors, but at the sides, after division of the mucous membrane, the cellular tissue is simply pushed up as high as possible, or till the pulsations of the uterine artery are felt. The finger is finally thrust through the utero-vesical fold of peritoneum, and after cleansing the vagina of clots and *débris* flat sponges are poked in around the uterus.

Douglas's pouch is entered in the same manner, controlling the hemorrhage from the vaginal wound by a few catgut sutures through its cut edges, and then the finger is hooked over the fundus, pulling it down into the posterior opening and thus bringing within reach the upper border of the broad ligaments, which are seized by long-bladed clamps and divided on the uterine side. Guided by the finger, other clamps are placed on the remaining tissues close to the uterus, which is then excised.

Injury to the ureters is avoided by thorough separation of the lower lateral cellular tissue early in the operation, the ureters being pressed forward with the anterior layer of the broad ligament. Richelet¹ leaves the clamps in place for twenty-four to forty-eight hours, but whenever possible it is better to secure with a silk ligature, at a proper distance from the clamps, the tissues in the grasp of each before they are severed from the uterus. Then if the adnexa can be separated and drawn down the pedicle of each may be secured with one or more clamps, which can be either left in place or the tissues in their grasp can be ligated with silk and the ovaries and tubes thus excised.

A rubber drainage tube surrounded by iodoform-gauze packing is placed in the vaginal wound and covered by an antiseptic dressing on the vulva.

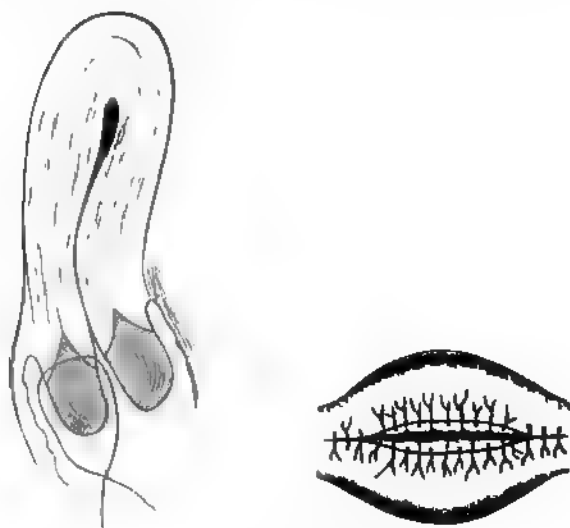
AMPUTATION OF CERVIX UTERI.

Infra-vaginal. The cervix may be removed with the bistoury or scissors, the *écraseur*, or the galvano-cautery:

¹ *Annals of Surgery* September 1892, p. 37.

flaps may be made and united as shown in Fig. 333. In the latter the cervix is split transversely from below up. The patient is placed in Sims's position, the speculum introduced, the cervix slit transversely, and each lip seized in turn with forceps, and cut off as near the vaginal junction as is considered proper. The mucous membrane of

FIG. 333.



A.

B.

Amputation of the cervix with double flaps. (Simon.)

A. Sectional view showing lines of incision for formation of flaps and method of suture.

B. Front view of cervix, operation complete. (Pozzi.)

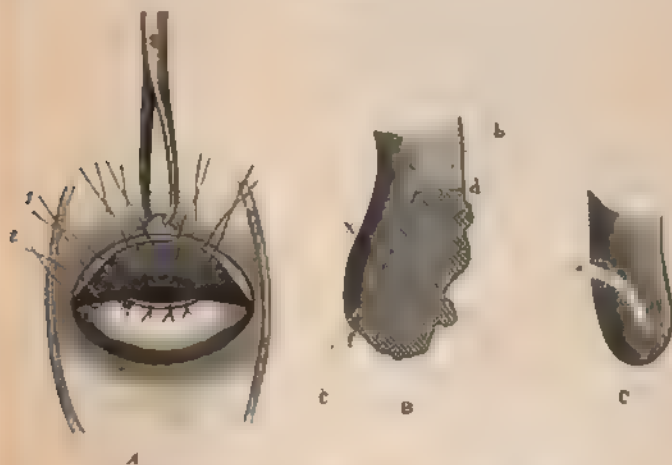
the interior is then drawn down and made fast with silver sutures to the outer edge of the cervix so as to cover in the raw surface. The hemorrhage is often very severe.

Supra-vaginal. After thorough disinfection of the external and internal genitals the patient is placed in the lithotomy position and the cervix is grasped by a volsella forceps. The mucous membrane around the cervix well clear of the disease is divided by scissors curved on the

flat, and, keeping close to the uterus, the mucous membrane is dissected or peeled off with the left forefinger and the scissors in front and behind, but at the sides, after the first incision of the mucous membrane, the cellular tissue between the broad ligaments is simply pushed aside.

When a point is thus reached in front and behind where the peritoneum ceases to strip up readily, guided by the finger, the structures within the broad ligaments are seized by long-bladed clamps close to the uterus and divided on

FIG. 334.



Amputation of cervix by one-flap or extension of the mucosa
(Schneider's operation.)

A Showing method of placing the sutures. 1 and 2 are those uniting the commensures.

B Section showing shape of incisions a-f and b-c line of suture.

C Shows position of flaps after suturing.

the uterine side. The uterus can then probably be dragged lower, and, with a sound in the canal, the uterine tissue is cut obliquely upward from the exterior to the sound, while the finger protects the surrounding parts, and in this way the cervix and a considerable portion of the body of the uterus is removed. A packing of iodoform gauze is placed in the vagina in contact with the cut surface, and

the clamps are left in place for twenty-four to forty-eight hours, when they can be removed without disturbing the packing.

Schroeder's Flap Operation for the Removal of Diseased Cervical Mucous Membrane. The cervix is split transversely from below up to the vault of the vagina and the front and back halves thus formed retracted. The mucous membrane and underlying tissue are then removed from the lower part of the cervical canal, as shown in Fig. 334, B f, e, d. After this the remaining external part of the cervix (Fig. 334, B, x) is folded in and sutured over the raw surface, as illustrated in Fig. 334, A and C. The operation is concluded by uniting the lateral commissures (Fig. 334, A, 1 and 2).

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